

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7806

CERTIFICATE OF DEATH

Reg. Dist. No. 07802

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 months 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13, Md.	
3. NAME OF DECEASED (Type or print) George		4. DATE OF DEATH 7 26 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman		10b. KIND OF BUSINESS OR INDUSTRY machine shop	
13. FATHER'S NAME Thomas Akers		14. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. 213-01-6838	
17. INFORMANT Springfield State Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CBS assoc. with senile brain disease, with psychotic reaction	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-12-1958 to 7-26-1958 , that I last saw the deceased alive on 7-26-1958 , and that death occurred at 2:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edmund Lusthaus M.D. Springfield State Hospital 7-26-58			
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) Edmund Lusthaus		22b. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 7-29-58		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem	
23. FUNERAL DIRECTOR'S SIGNATURE McCalley Funeral Home		22d. LOCATION (City, town, or county) Baltimore (State) MD	
ADDRESS 130 E Fort St		24a. REC'D BY REGISTRAR DATE JUL 29 '58	
		24b. REGISTRAR'S SIGNATURE Alt. couch	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b lyr. 7mos. 16days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Zone 6.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital	d. STREET ADDRESS 3614 Eastwood Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
15	3. NAME OF DECEASED (Type or print) Grace Emma Hofmann	First Middle Last	4. DATE OF DEATH July 13, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 2, 1890	9. AGE (in years less birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) New Jersey	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Hofmann	14. MOTHER'S MAIDEN NAME Mary Hartwick	16. SOCIAL SECURITY NO. 057-16-4720 17. INFORMANT Springfield Hospital Records		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 057-16-4720	17. INFORMANT Springfield Hospital Records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown.				
20c. TIME OF INJURY Hour a. m. Unknown	Month, Day, Year 7/5/58 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Sykesville (County) Carroll (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE James T. Marsh, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 7/14/58
22a. DATE OF CREMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL Established 1910	22d. LOCATION (City, town or county) Baltimore (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Luck	ADDRESS 305 Harford	24a. REC'D BY REGISTRAR DATE JUL 16 '58	24b. REGISTRAR'S SIGNATURE Albert J. Luck	
VS. A15ME SM 2/57				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7808

CERTIFICATE OF DEATH

Reg. Dist. No.

07804

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural		c. LENGTH OF STAY IN 1b 3 y. 9 m. 29 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, 1556.3			
3. NAME OF DECEASED (Type or print) Elizabeth		First Margaret	Middle Ashby		
4. DATE OF DEATH July		Month 14	Day Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1869		
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0		
12. IF UNDER 24 HRS. Hours 0		13. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home			
10c. BIRTHPLACE (State or foreign country) Washington, D. C.		11. MOTHER'S MAIDEN NAME Mary Barbara Tauber-Schmidt			
12. FATHER'S NAME John William Wagner		13. MOTHER'S MAIDEN NAME Mary Barbara Tauber-Schmidt			
14. PARENT'S NAME John William Wagner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield Hospital Record			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		19. INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance, with</u> <u>with cerebral arteriosclerosis, with psychotic reaction.</u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 20d. INJURY OCCURRED While p. m. Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1, 1955</u> , to <u>July 14, 1958</u> , that I last saw the deceased alive on <u>July 13, 1958</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		22. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23. FUNERAL DIRECTOR'S SIGNATURE Warren S. Humphrey	
22b. DATE THEREOF 7/17/58		22c. NAME OF CEMETERY OR CREMATORIUM PROSPECT HILL CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
24. REC'D BY REGISTRAR DATE JUL 16 '58		24b. REGISTRAR'S SIGNATURE DeLoach			
VS A15 (4) 15M 9/55					

STATE OF HAWAII - DEPARTMENT OF
CERTIFICATE OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN **HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the death certificate should be detached for use as a burial transit permit.

VS AISC 1.55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7809 CERTIFICATE OF DEATH

07805

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY CARROLL MARYLAND
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN NEW WINDSOR LENGTH OF STAY
 (in this place)
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS MAIN ST

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY CARROLL
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN NEW WINDSOR
 STREET ADDRESS MAIN ST
 (If rural give location)

3. NAME OF
 DECEASED
 (Type or Print)ERSCIE GLENROY BENEDICT4. DATE
 (Month)
 OF
 DEATHJULY 25 1958

5. SEX

6. COLOR OR
 RACE7. SINGLE, MARRIED,
 WIDOWED, DIVORCED,
 (Specify)10a. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if
 retired)10b. KIND OF BUSINESS
 OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
 COUNTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, No, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

20. AUTOPSY?

YES NO

21. IMMEDIATE CAUSE

(A) DUE TO

22. ANTECEDENT CAUSE(S)

(B) DUE TO

23. DISEASES OR CONDITIONS, IF ANY,
 GIVING RISE TO THE ABOVE CAUSE
 STATING UNDERLYING CAUSE LAST.

(C) DUE TO

24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
 TO THE DEATH BUT NOT RELATED TO THE
 DISEASE OR CONDITION CAUSING DEATH.

25. DATE OF OPERATION

26. MAJOR FINDINGS OF OPERATION

27. ACCIDENT WAS UNDERLYING
 OR CONTRIBUTING CAUSE OF DEATH
 (If either, NOTIFY MEDICAL EXAMINER)28. PLACE (Home, farm, factory,
 OF INJURY street, office bldg., etc.)

29. WHERE DID INJURY OCCUR? (City or town)

(County) (State)

30. TIME OF INJURY (Month) (Day) (Year) (Hour)

31. INJURY OCCURRED
 While
 at work
 Not while
 at work

32. HOW DID INJURY OCCUR?

33. BURIAL, CREMATION,
 REMOVAL (SPECIFY)

34. DATE THEREOF

NAME OF CEMETERY OR CREMATOR

LOCATION (City, town, or county)

(State)

35. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

36. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE JUL 29 1958

As Requested

37. HARTZLER & SONS, NEW WINDSOR, MD

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21. ADDRESS-NAME TO THE STATE AND TERRITORY

MAILED TO STATIONES 6007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

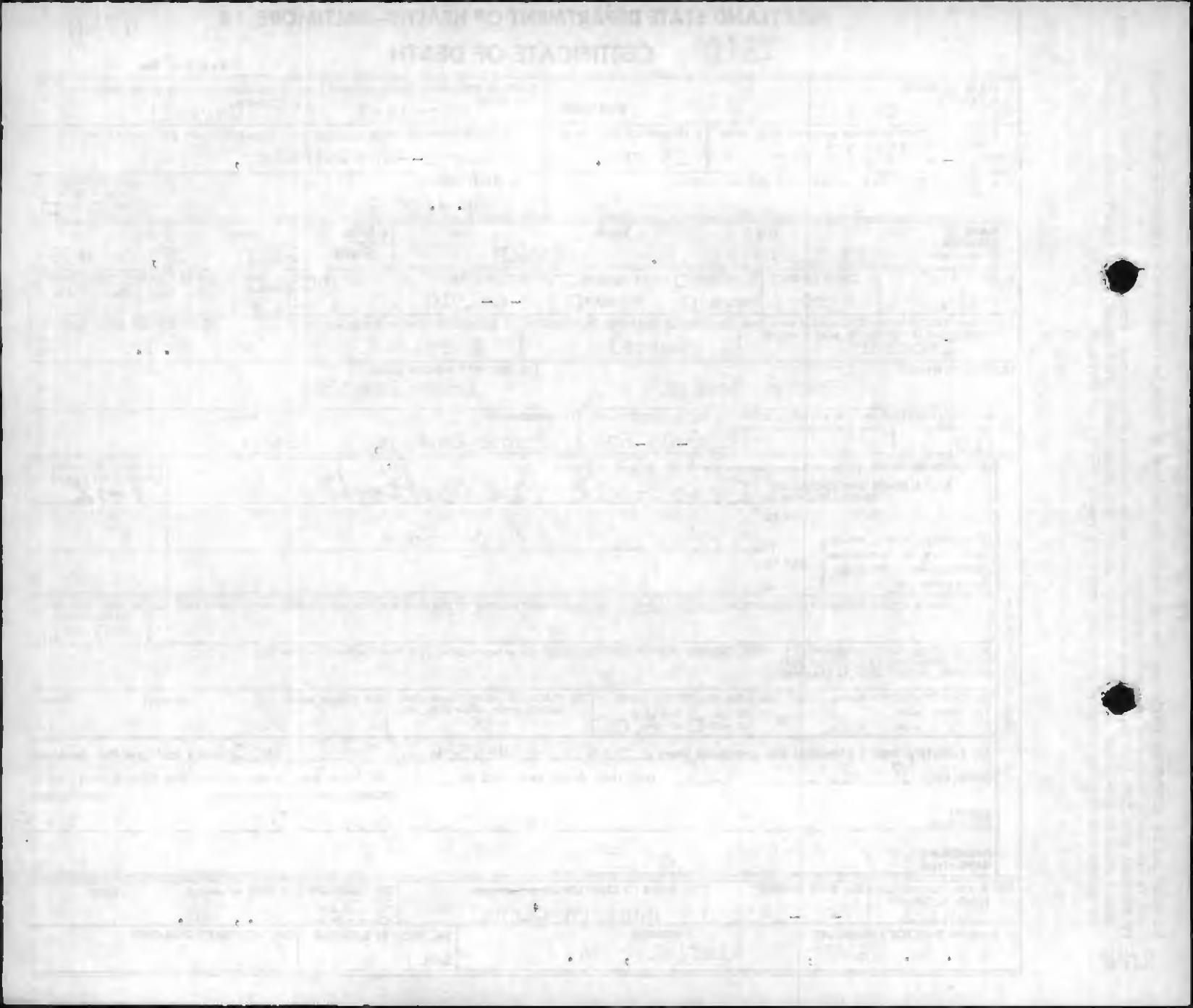
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CERTIFICATE OF DEATH

07808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westminster		c. LENGTH OF STAY IN 1b 15 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural--Westminster,				
3. NAME OF DECEASED (Type or print) CHARLES		First N.	Middle BOWMAN			
4. DATE OF DEATH JULY 27, 1958		Month Day Year				
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-1910			
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general				
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Henry Bowman		14. MOTHER'S MAIDEN NAME Irene Broadus				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 206-03-6069				
17. INFORMANT Frank Bowman, Same		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 MTH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <input checked="" type="checkbox"/> 19 p. m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	20f. (City or town) X	(County)	(State)
21. I certify that I attended the deceased from <u>7-28-58</u> to <u>7-27-58</u> , 1958, that I last saw the deceased alive on <u>7-27-58</u> , and that death occurred at <u>SP</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>Westminster</u> DATE SIGNED <u>7-28-58</u>						
ACTUAL SIGNATURE <u>W. P. STONE</u>		PHYSICIAN'S NAME (Type) <u>W. P. STONE</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-30-1958</u>	22c. NAME OF CEMETERY OR CEMATORIY <u>Western Chapel</u>	22d. LOCATION (City, town, or county) <u>Carroll Co., Md.</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. WALTZ,</u>		ADDRESS <u>Winfield, Md.</u>	24a. REC'D BY REGISTRAR DATE JUL 30 '58		24b. REGISTRAR'S SIGNATURE <u>Asst. Sec.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7811 CERTIFICATE OF DEATH

Reg. Dist. No.

07807

1. PLACE OF DEATH a. COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE		Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 1yr. 3mths. ldy.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore City 311			
Sykesville				Baltimore 24					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TLTION		Springfield State Hospital.		d. STREET ADDRESS		634 South Macon Street			
3. NAME OF DECEASED (Type or print)		First Catherine	Middle Rossmeisl	Last Brooks	4. DATE OF DEATH	Month 7	Day 8	Year 1958	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years at birthday) 65 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days		
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-2-1893		Hours	Min.		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			
						12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Anton Rossmeisl.			14. MOTHER'S MAIDEN NAME Pauline Berg.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO 213-01-5364			17. INFORMANT Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH days.			
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Involutional psychotic reaction.									
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from		4-5-	1957	7-8-58	, 19		, 19		
alive on		7-8-	1958	8-10 P.M.	, 19		, 19		
, and that death occurred at					, 19		, 19		
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) Springfield State Hospital.						DATE SIGNED 7-8-58	
PHYSICIAN'S NAME (Type)		Agustin del Campo, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Burial-cremation		1958		Loudon Park		Baltimore		Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Hippert Funeral Home		Baltimore, Md.		JUL 11 '58		Webber			



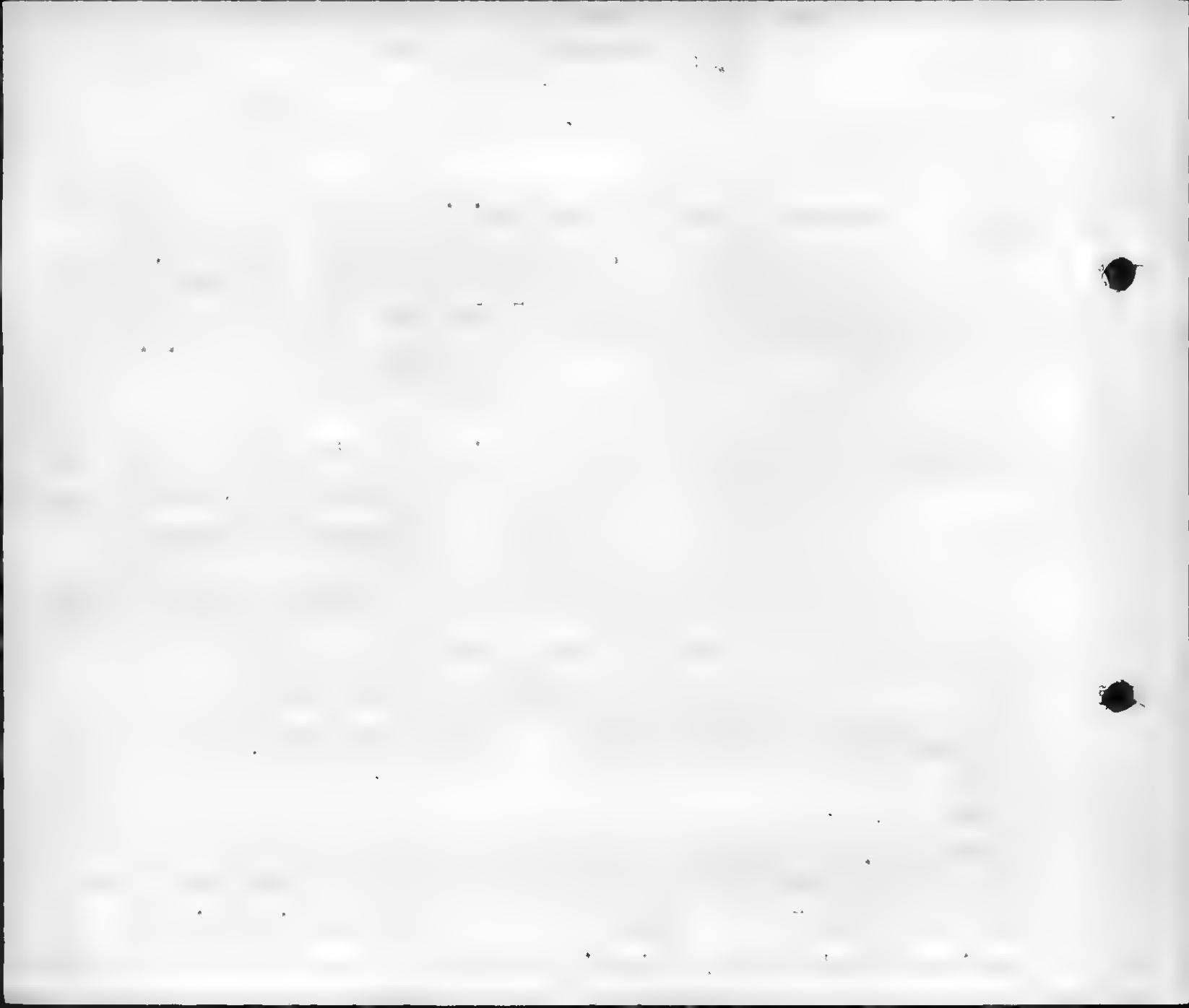
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07868

Reg. Plat. No.

- HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
- FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use. The burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland		If institution- Residence before admission b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gamber		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gamber		d. STREET ADDRESS R.D. Finksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE		First M.		Middle BROTHERS		4. DATE OF DEATH JULY 28,	Month Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-1872		9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer--retired		10b. KIND OF BUSINESS OR INDUSTRY own		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Brothers		14. MOTHER'S MAIDEN NAME Katherine Poole					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John L. Brothers, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Renal Disease</i> INTERVAL BETWEEN ONSET AND DEATH 44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Myocardial degeneration</i> & years DUE TO Decompensation after 5 years (c) <i>After 5 years</i> 50 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 1957</i> to <i>July 28, 1958</i> , that I last saw the deceased alive on <i>July 25, 1958</i> , and that death occurred at <i>3430 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>John Glenn Speicher</i> <i>July 28, 1958</i>							
PHYSICIAN'S NAME (Type) T. GLENN SPEICHER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-31-1958		22c. NAME OF CEMETERY CREMATORIUM Providence		22d. LOCATION (City, town, or county) Gamber, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ,		ADDRESS Winfield, Md.		24a. REC'D. BY REGISTRAR JUL 30 '58		24b. REGISTRAR'S SIGNATURE Alfred Beach	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

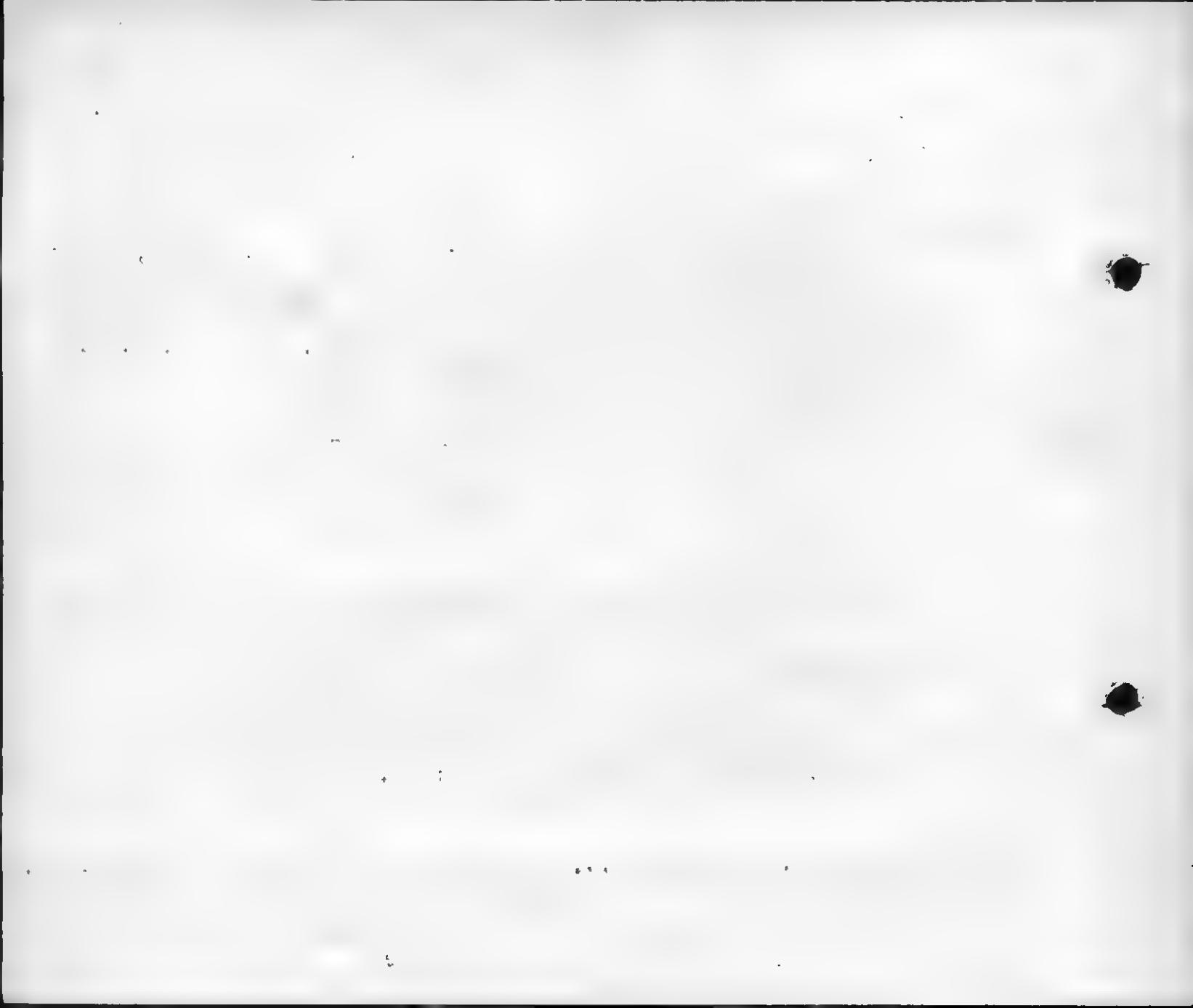
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7813 CERTIFICATE OF DEATH

07809
Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Kent Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 16 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS 108 College Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Samuel	Middle	Last Brown	4. DATE OF DEATH	Month July	Day 1	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1895	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Uniontown, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Standon Brown				14. MOTHER'S MAIDEN NAME Hattie Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT Samuel Brown - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency							
DUE TO 201X							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Far advanced tumor of the right lung							
DUE TO (c) Pneumonitis of the right lung							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1958 , to July 1, 1958 , that I last saw the deceased alive on July 1, 1958 , and that death occurred at 9:15 a.m. from the causes and on the date stated above							
ADDRESS (Street, city or town, state) Edgars M. Maculans, M.D.							
ACTUAL SIGNATURE Edgars M. Maculans, M.D.							
DATE SIGNED 7/1/58							
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D., Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-4-58	22c. NAME OF CEMETERY OR CREMATORIUM Janes Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wilis Wells							
ADDRESS Chestertown, Md.							
24a. REC'D BY REGISTRAR 58							
24b. REGISTRAR'S SIGNATURE Wilis Wells							
DATE JUL 3							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7814 CERTIFICATE OF DEATH

07810
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wyesville</i>		c. LENGTH OF STAY IN 1b c. STREET ADDRESS <i>Wyesville 1st Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wyeless Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William H. Carter</i>	First	Middle	Last
4. DATE OF DEATH <i>7/26/58</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/9/1867</i>
9. AGE (In years (and birthday) years months days hours min)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman, Gas & Elec</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Gas & Elec</i>	12. BIRTHPLACE (State or foreign country) <i>Md</i>
13. FATHER'S NAME <i>James Frazier H. Elmore</i>	14. MOTHER'S MAIDEN NAME <i>1968 E. Greenwich, Westminster</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>491X</i>
17. INFORMANT <i>W</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIAL ARREST, Coronary Thrombosis Arteriosclerotic Heart Dis, Anemia, Bronchial pneumonia	
		INTERVAL BETWEEN ONSET AND DEATH <i>21 July 58</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>491X</i>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11 July 1958</i> to <i>26 July 1958</i> , that I last saw the deceased alive on <i>26 July 1958</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Howard E. Hall, M.D., Carroll, Md.</i>	
ACTUAL SIGNATURE <i>Howard E. Hall</i>	PHYSICIAN'S NAME (Type) <i>Howard E. Hall</i>	DATE SIGNED <i>26 July 58</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/30/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>London Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Neill & Sons</i>	ADDRESS <i>Mac Neill & Sons</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 31 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alt. enoch</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

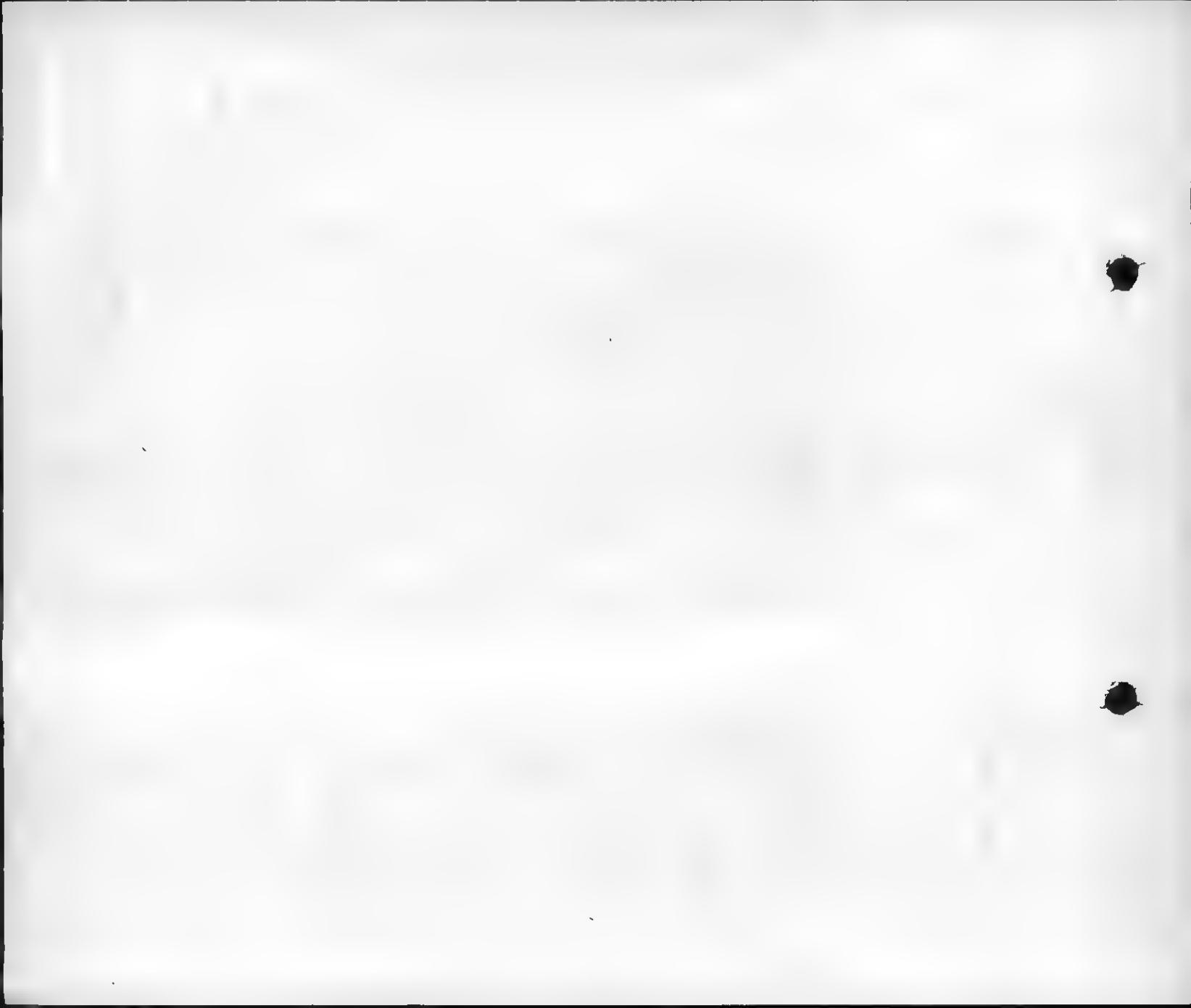
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7815 CERTIFICATE OF DEATH

07811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>		c. LENGTH OF STAY IN 1b <i>50 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>DENTON CONDON</i>		First <i>D</i>	Middle <i>E</i>
4. DATE OF DEATH <i>July 4 1958</i>	Month <i>July</i>	Day <i>4</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 26, 1881</i>
9. AGE (In years last birthday) <i>74 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
13. IF UNDER 24 HRS Min <i>0</i>	14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>Yuk</i>		16. SOCIAL SECURITY NO. <i>44-12-1212</i>	
17. INFORMANT <i>Yuk. Mrs. Hannah Condon - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterosclerotic heart disease,</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Creamy thrombosis, Cerebral thrombosis.</i> DUE TO (c) <i>Anemia,</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1954 to 1958</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>July 4 1958</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Sykesville, Md. Carroll, Md.</i>	
21. I certify that I attended the deceased from <i>1954</i> to <i>1958</i> , that I last saw the deceased alive on <i>4 July 1953</i> , and that death occurred at <i>9:40 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Howard E. Hall</i>			
ADDRESS (Street, city or town, state) <i>Sykesville, Md.</i> DATE SIGNED <i>3 July 58</i>			
22a. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22b. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i> 22c. DATE THEREOF <i>7-7-58</i> 22d. NAME OF CEMETERY OR CREMATORIUM <i>Freedom</i> 22e. LOCATION (City, town, or county) (State) <i>Collegesburg Carroll, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Height Sykesville, Md.</i>		24a. ADDRESS ADDRESS DATE <i>July 9 1958</i> 24b. REC'D BY REGISTRAR DATE <i>July 9 1958</i> 24c. REGISTRAR'S SIGNATURE <i>West Beach</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use. The burial-transit permit, then please remove carbon paper, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 3211774/12/58

7816

CERTIFICATE OF DEATH

Reg. Dist No 812

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND		b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYMAR		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYMAR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL		d. STREET ADDRESS 1 RURAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMELIA		First C.	Middle CRABB	4. DATE OF DEATH JULY 11 1958	Month Day Year
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		9. b. DATE OF BIRTH 1877		10. c. AGE (In years last birthday) 84 yrs.	
10. b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN COPE HAVENS		14. MOTHER'S MAIDEN NAME JANE STULTZ		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. DONALD LAMBERT, KEYMAR		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 252.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Nursing Parson Conflict Supp. M. 11/11/58	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1958</u> to <u>July 11, 1958</u> , that I last saw the deceased alive on <u>June 11, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED JULY 11 1958	
ACTUAL SIGNATURE J. H. MESSLER, M.D.		PHYSICIAN'S NAME (Type) J. H. MESSLER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 17/11/58		22c. NAME OF CEMETERY OR CREMATORIAL MUNION CEM. CARROLL COUNTY MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. H. Harkleroad Union Budgeted		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 16 '58	
				24b. REGISTRAR'S SIGNATURE A. L. Smith	

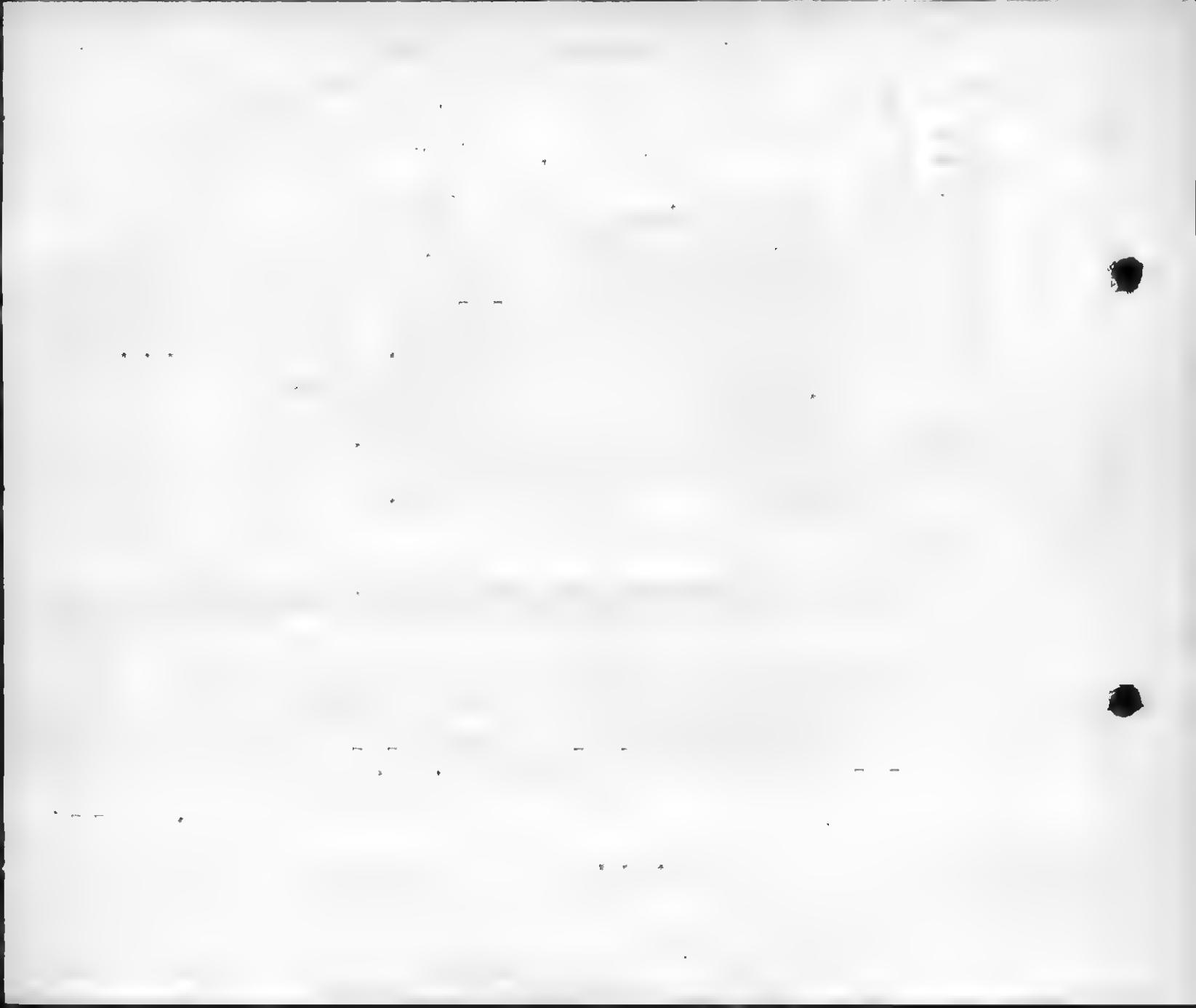


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7817 CERTIFICATE OF DEATH

Reg. Dist. No. 07813

1. PLACE OF DEATH o COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland b. COUNTY Baltimore City 311					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 29 yrs, 5 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Virginia	Middle Sherwood	Lost Demitz.				
4. DATE OF DEATH	Month 7	Day 6	Year 19 58				
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-29- 82				
9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0				
13. FATHER'S NAME John R. Sherwood	14. MOTHER'S MAIDEN NAME Isabel Miller	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If no or unknown) Unknown			16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Hospital records.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease.							
420.0 not Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) due to intestinal obstruction							
DUE TO due to DUE TO (c) incarcerated left Femoral Hernia.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
19							
21. I certify that I attended the deceased from 7-6- 58, and that death occurred at 5-20 P.M.,				that I last saw the deceased alive on 7-6- 58, from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustín del Campo.				ADDRESS (Street, city or town, state) Springfield State Hospital, M.D.			
PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.				DATE SIGNED 7-6-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-58		22c. NAME OF CEMETERY OR CREMATORIUM David Hodge		22d. LOCATION (City, town, or county) Towson, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Homer A. Haight Sykesville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 10 '58		24b. REGISTRAR'S SIGNATURE Albert Smith	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7818 CERTIFICATE OF DEATH

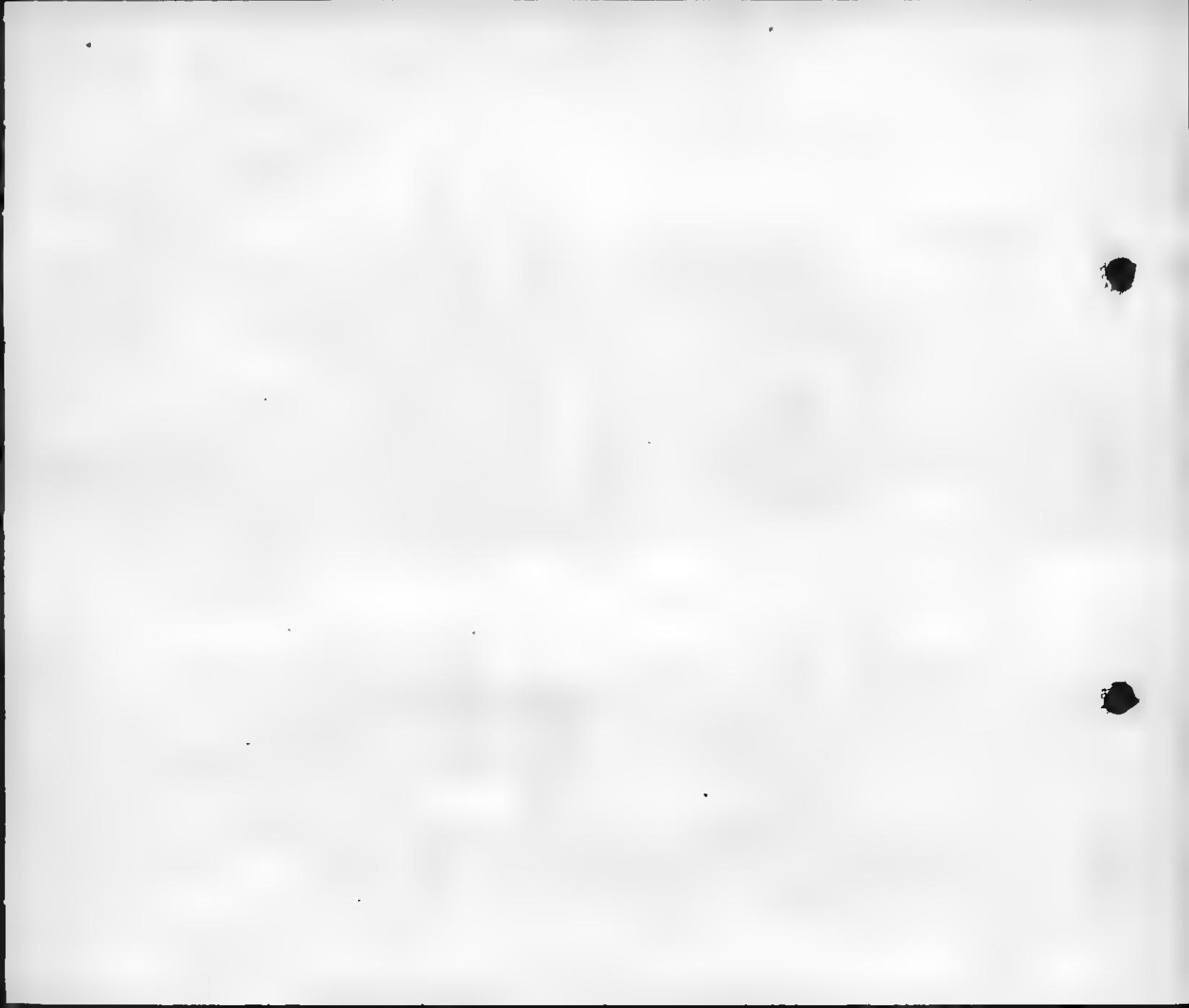
Reg. Dist. No.

07814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marchesque MD</i>		c. LENGTH OF STAY IN 1b <i>2 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary E. Geraldine DRISCOLL</i>		First	Middle
4. DATE OF DEATH Month <i>July</i> Day <i>21</i> Year <i>1958</i>		Last	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH <i>February 18 1874</i>		8. AGE (in years, last birthday) <i>84 yrs</i>	9. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Patrick Moylear</i>	
14. MOTHER'S MAIDEN NAME <i>Sweeney</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>212-12-6852</i>		17. INFORMANT <i>Mary DRISCOLL, New Windsor MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant Cervical Carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>(?)</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Primary Cervical Carcinoma of Colon</i>		DUE TO <i>(?)</i>	
(c) <i>Adhesions due to Cancerous Disease</i>		DUE TO <i>(?)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Adhesions due to Cancerous Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Hampstead</i> (County) <i>Carroll</i> (State) <i>Maryland</i>	
21. I certify that I attended the deceased from <i>May 16, 1958</i> to <i>July 21, 1958</i> that I last saw the deceased alive on <i>July 19, 1958</i> , and that death occurred at <i>Hampstead</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph F. Bush MD</i>		ADDRESS (Street, city or town, state) <i>Hampstead MD</i> DATE SIGNED <i>7/21/58</i>	
PHYSICIAN'S NAME (Type) <i>Joseph F. Bush MD</i>		HAMPSTEAD MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/24/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>		ADDRESS <i>3000 E. Baltimore Street</i>	
24a. REC'D BY REGISTRAR DATE JUL 23 '58		24b. REGISTRAR'S SIGNATURE <i>John A. Moran</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

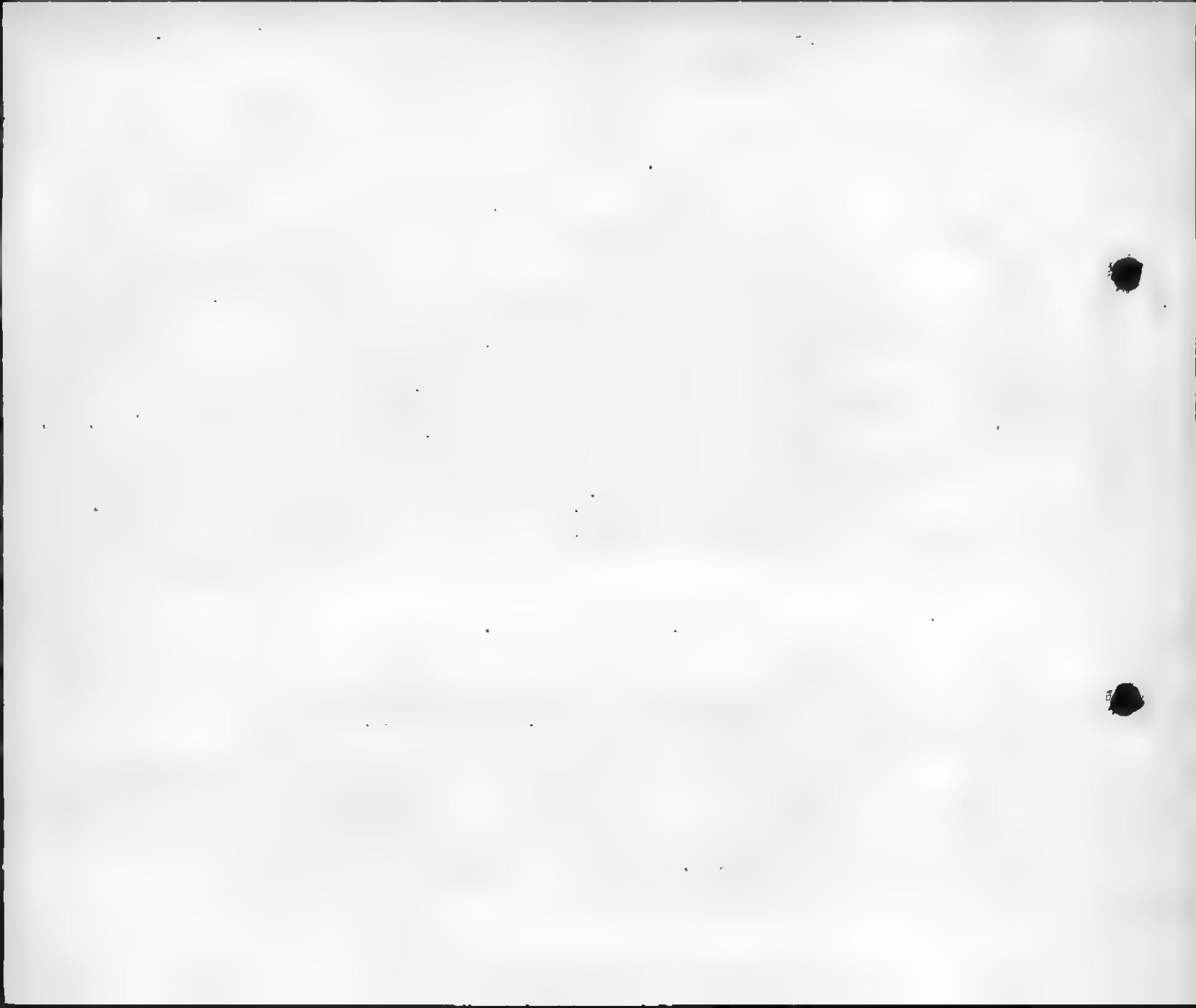
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7819 CERTIFICATE OF DEATH

07815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 2 yrs. 10 days		a. STATE Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				b. COUNTY Carroll	
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Winfield				c. STREET ADDRESS 1 P.S.D. Woodbine	
d. STREET ADDRESS 1 P.S.D. Woodbine				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Otho	Last FLEMING	4. DATE OF DEATH	Month July
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 6, 1882	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME Samuel Fleming		14. MOTHER'S MAIDEN NAME Ada Anizis		12. CITIZEN OF WHAT COUNTRY? United States	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address Sykesville, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the cecum, with metastases to the liver (recurrent)</u>				INTERVAL BETWEEN ONSET AND DEATH months	
153.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c) _____				3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Manic depressive reaction, depressed type.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Dec. 13, 1956, to June 30, 1958, that I last saw the deceased alive on June 30, 1958, and that death occurred at 4:00 A.M., from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED Walter Knopp, M.D. Springfield State Hospital 7-1-58					
ACTUAL SIGNATURE					
PHYSICIAN'S NAME (Type) Walter Knopp, M. D. Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-1958		22c. NAME OF CEMETERY OR CEMETARY Morgan Chapel	
22d. LOCATION (City, town, or county) Carroll Co. Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. T. Knopp		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 3 '58	
				24b. REGISTRAR'S SIGNATURE Aud. Rec'd.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07816

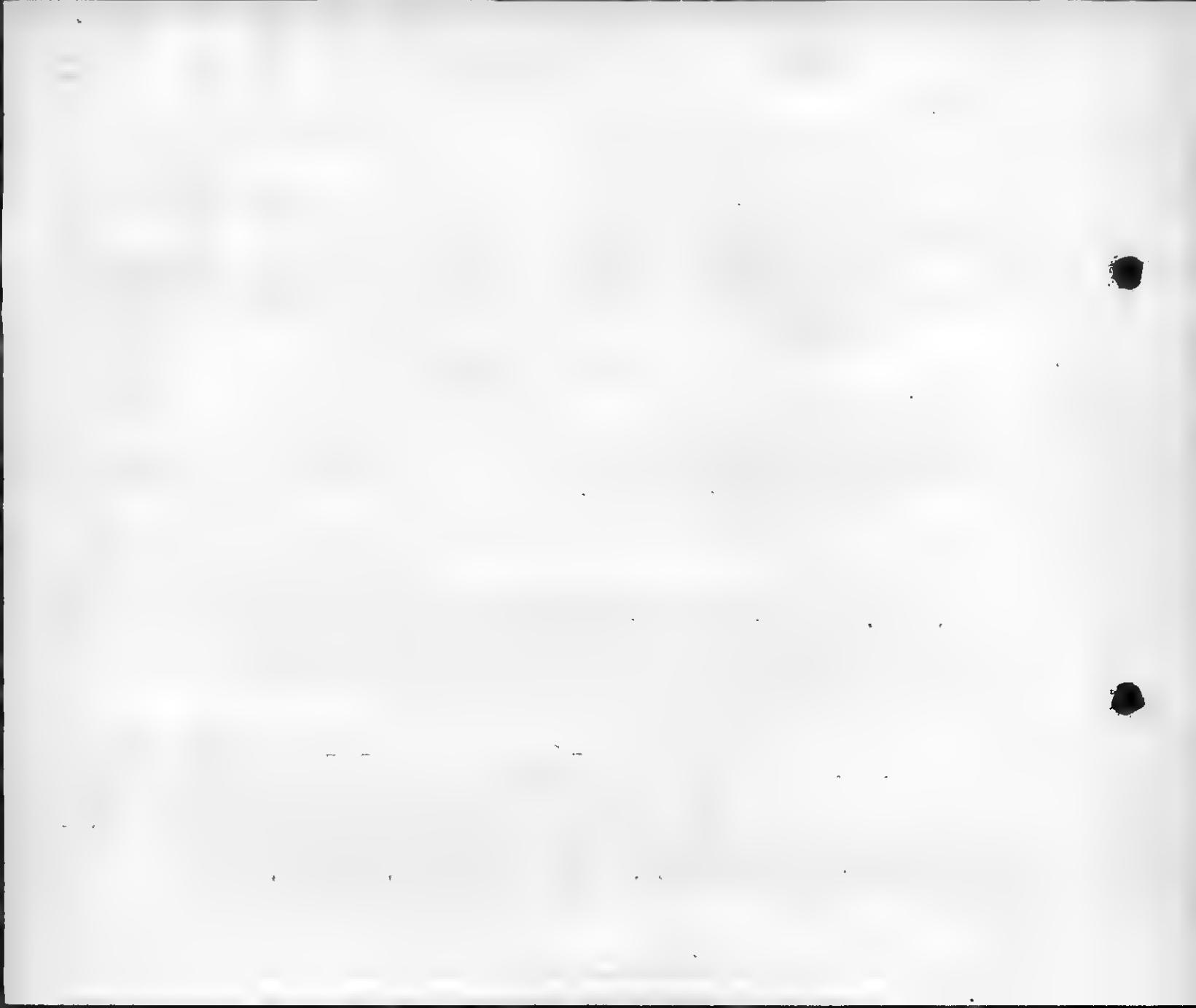
7820

CERTIFICATE OF DEATH

Item 11. File No. 12-24-58-61

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 to 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		d. STREET ADDRESS Clover Nursing Home County Home (Carroll Co.)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George E. Eugene		First	Middle	4. DATE OF DEATH 7-25-58	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-69	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) unkn		16. SOCIAL SECURITY NO. unkn		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X						INTERVAL BETWEEN ONSET AND DEATH days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. RECOR		(b) Arteriosclerotic cardiovascular disease				years	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS. assoc. with cerebral arteriosclerosis, with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7-25-58		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 7-25-58 , and that death occurred at 7 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>						DATE SIGNED 7-26-58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-58		22c. NAME OF CEMETERY OR CREMATORIUM WESTMINSTER CEM. WESTMINSTER 17		22d. LOCATION (City, town, or county) (State) Westminster, MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>David A. Barkard</i>		ADDRESS Westminster, MD		24a. REC'D BY REGISTRAR DATE JUL 30 '58		24b. REGISTRAR'S SIGNATURE Alt. eauh	



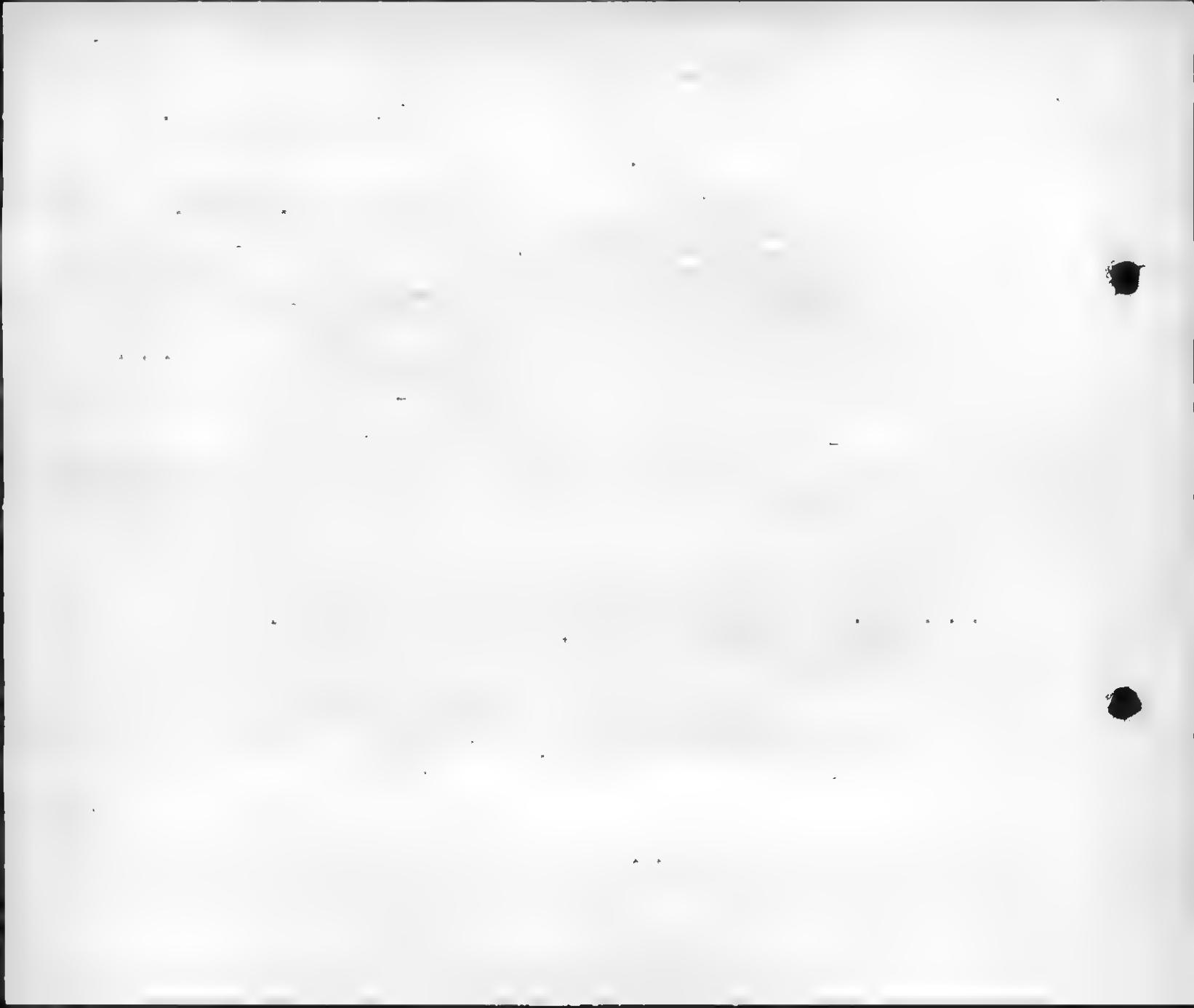
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07817

7821 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5mos. 26days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1558 Abbottston St., Zone 18.		d. DATE OF DEATH July 2, 1958			
3. NAME OF DECEASED (Type or print)	First Anna	Middle Mae	Surname Stabler	Lost Forrester	Month July	Day 2	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1885		9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stabler				14. MOTHER'S MAIDEN NAME Artilda -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO No -		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH Days							
C. B. S. assoc. with senile brain disease with psychotic reaction. Intertrochanteric fracture right hip.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 6, 1958</u> to <u>July 2, 1958</u> , that I last saw the deceased alive on <u>July 1, 1958</u> , and that death occurred at <u>12:05AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. Springfield State Hospital 7/2/58							
PHYSICIAN'S NAME (Type)		Edmund Lusthaus, M.D. Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-5-58		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore		22d. LOCATION (City, town or county) Balto 2nd (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Leonard J. Luck 5305 Harford		24a. REC'D BY REGISTRAR DATE JUL 7 '58		24b. REGISTRAR'S SIGNATURE C. L. Smith	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

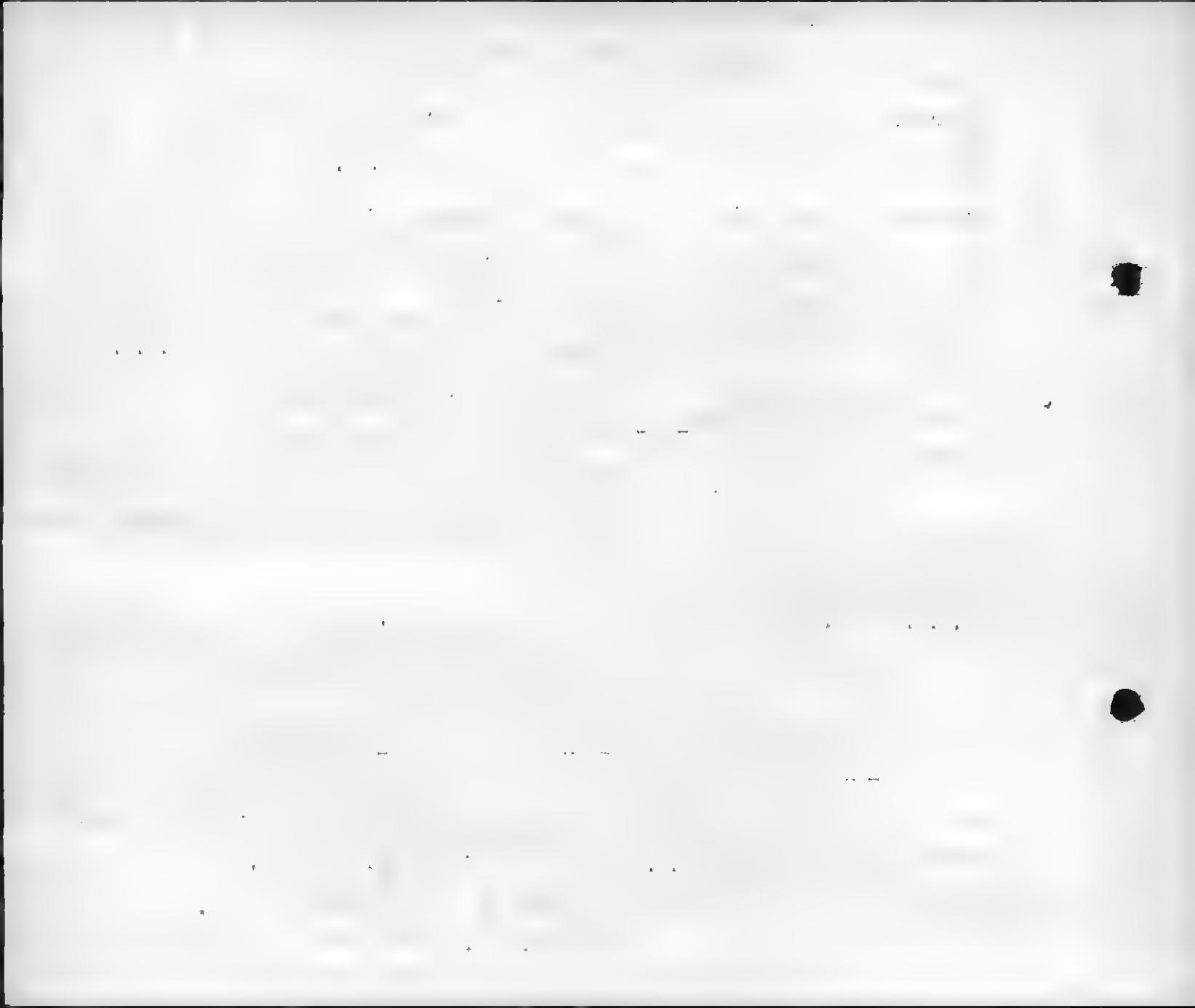
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7822 CERTIFICATE OF DEATH

07818
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 month 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Md.	
3. NAME OF DECEASED (Type or print) Rella		d. STREET ADDRESS 109 Second Street	
First Rella		Middle Elmer	
Last Fraze		4. DATE OF DEATH 7 5 1958	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-17-78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Wood working	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hamilton Fraze		14. MOTHER'S MAIDEN NAME Mary Susan White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. 233-20-0782A	
17. INFORMANT unkn		Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with senile brain disease, with psych. reaction			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-13- 1958 to 7-4- 1958 that I last saw the deceased alive on 7-4- 1958 , and that death occurred at 2:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7-5-58			
ACTUAL SIGNATURE <i>Edmund Lusthaus</i> M.D.			
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>T. L. Leighton</i>		ADDRESS Oakland, Md.	
24a. REC'D. JUL 10 1958		24b. REGISTRAR'S SIGNATURE <i>W. L. Leighton</i>	
DATE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07819

7823 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE	
3. NAME OF DECEASED (Type or print) GRETZELDA PAULINE FUSS		d. STREET ADDRESS RURAL	
4. DATE OF DEATH JULY 24 1958		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1889	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER, PUB. SCHOOLS, RET		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JESSE FUSS		14. MOTHER'S MAIDEN NAME EFFIE GEIGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT EDNA FUSS, UNION BRIDGE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 6 , p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) UNION BRIDGE (State) M.D.	
21. I certify that I attended the deceased from Apr. 28, 1958 to July 24, 1958 that I last saw the deceased alive on 7-22-1958 and that death occurred at 11:54 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. N. Legg M.D. Union Bridge, Md DATE SIGNED 7-24-58		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 7/26/58		22b. DATE THEREOF 7/26/58	
22c. NAME OF CEMETERY OR CREMATORIAL WINTERS CEM NEW WINDSOR		22d. LOCATION (City, town, or county) RURAL M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE Old Hartley & Sons Union Bridge Md		24a. REC'D BY REGISTRAR DATE JUL 28 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Deborah	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

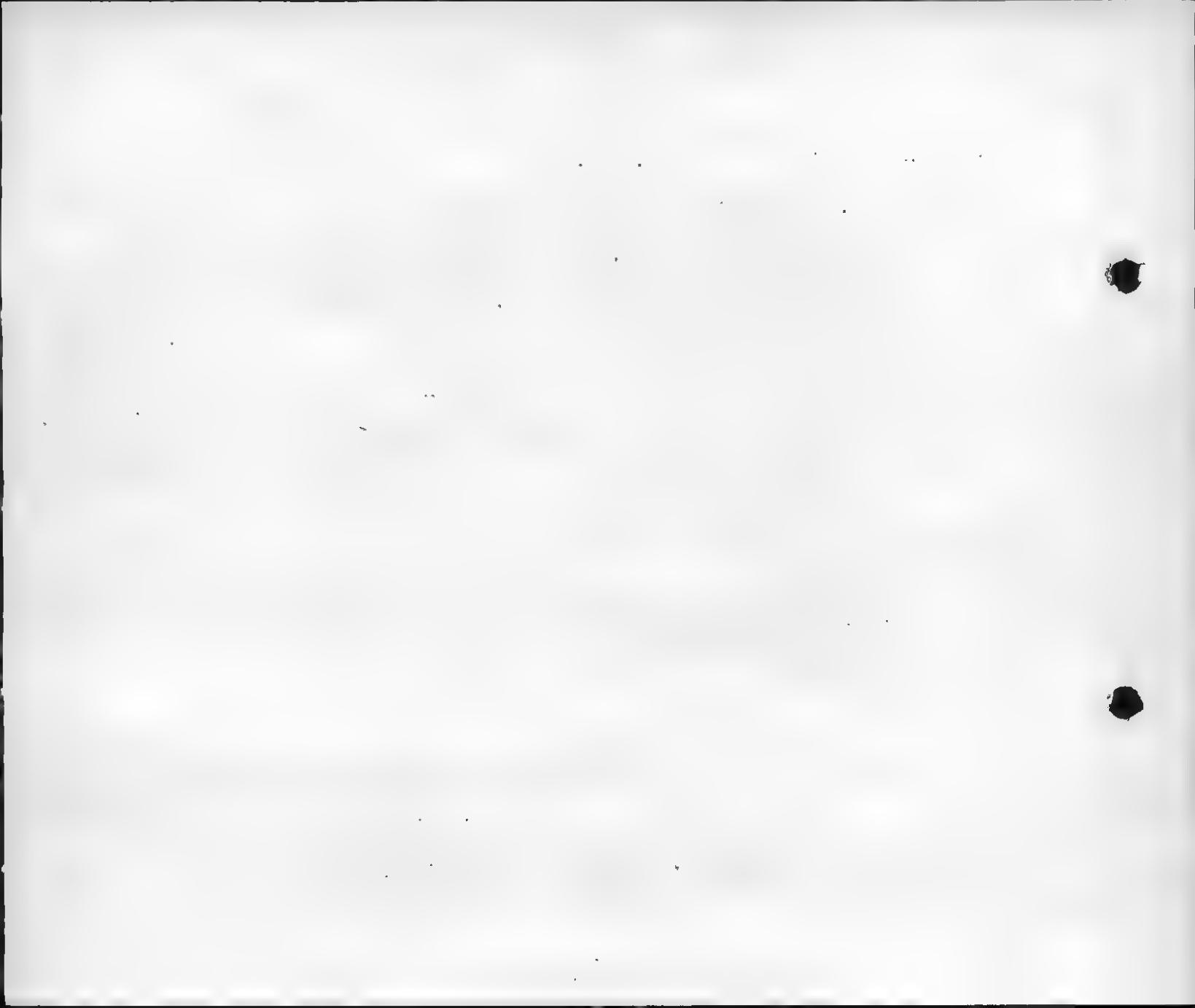
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7824 CERTIFICATE OF DEATH

07820
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 20yrs. 9mos. 9das. Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS unknown	
3. NAME OF DECEASED (Type or print) Thomas		First W.	Middle Lost
4. DATE OF DEATH GILCHRIST		Month July	Day 31
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec. 15, 1892		9. AGE (In years (last birthday) 65 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months — Days — Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Yak	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Thomas Gilchrist	
14. MOTHER'S MAIDEN NAME Kate - Hank		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) no	
16. SOCIAL SECURITY NO unknown		17. INFORMANT Records of Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Pyelonephritis			
DUE TO			
(c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Psychosis with mental deficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —		(County) (State) —	
21. I certify that I attended the deceased from August 19, 55 to July 31, 1958 , that I last saw the deceased alive on July 31, 1958 , and that death occurred at 11:15A M , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) —			
DATE SIGNED 8/4/58			
MEDICAL CERTIFICATION			
ACTUAL SIGNATURE Walter Knopp			
PHYSICIAN'S NAME (Type) Walter Knopp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-58	
22c. NAME OF CEMETERY OR Crematory New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Haight Sykesville, Md.		24a. REC'D BY REGISTRAR DATE AUG 7 '58	
ADDRESS —		24b. REGISTRAR'S SIGNATURE Al. Knopp	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7825

CERTIFICATE OF DEATH

07821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 27 yrs. 3 mos. 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS 3 N. Foundry St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lula	Middle P.	Last GREEN
4. DATE OF DEATH	Month July	Day 28,	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1876
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Henry Robertson		14. MOTHER'S MAIDEN NAME Mary James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) No	16. SOCIAL SECURITY NO. - - -	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) X DUE TO Pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dementia Praecox, Hebephrenic type.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital
20f. (City or town) Sykesville, Maryland		(County)	(State)
21. I certify that I attended the deceased from October 20, 1954 , to July 28, 1958 , that I last saw the deceased alive on July 28, 1958 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		DATE SIGNED 7/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 31, 1958		22c. NAME OF CEMETERY OR CREMATORIAL St. James Chapel	22d. LOCATION (City, town, or county) Monocacy, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Letter Funeral Home, Sykesville, Md.		24a. REC'D BY REGISTRAR JUL 31 '58	24b. REGISTRAR'S SIGNATURE Rebecca



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

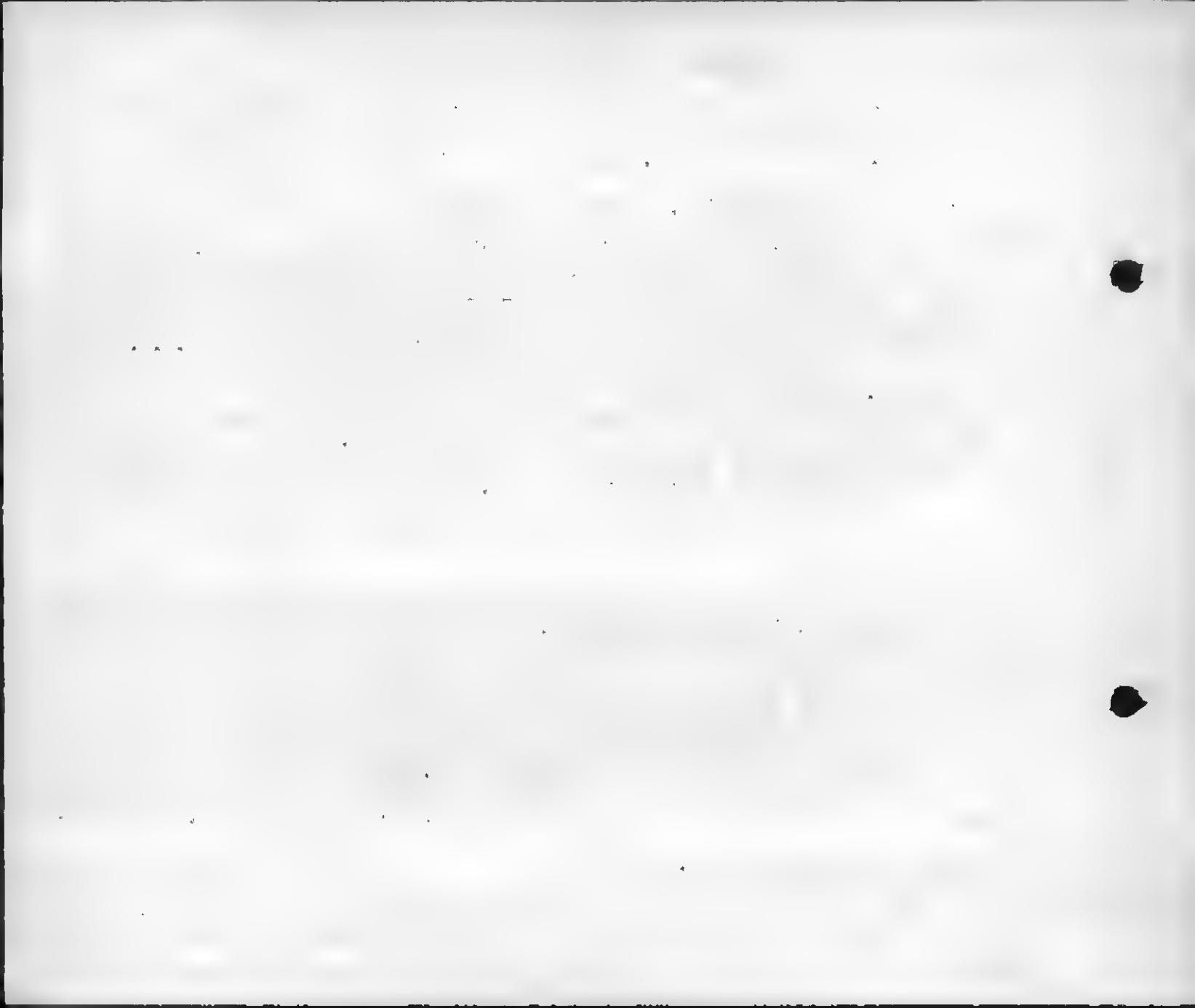
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7826 CERTIFICATE OF DEATH

07822
Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville.		b. COUNTY Caroline	
c. LENGTH OF STAY IN 1b 10 yrs. 9 mths 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS Unknown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sarah	Middle Addie	Last Griffin
4. DATE OF DEATH	Month 7	Day 20	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-74
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John H. Griffin	14. MOTHER'S MAIDEN NAME Unknown	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis.			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Senile Psychosis, simple deterioration.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>March 7, 1955</u> to <u>July 20, 1958</u> , that I last saw the deceased alive on <u>July 20, 1958</u> , and that death occurred at <u>12:55 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield State Hospital.	
PHYSICIAN'S NAME (Type) Agustin del Campo.		DATE SIGNED 7-20-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jul 1/22, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Greensboro Cemetery	22d. LOCATION (City, town, or county) Greensboro Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks, Elkins Md</i>	ADDRESS <i>Ralph E. Hicks, Elkins Md</i>	24a. REC'D BY REGISTRAR DATE JUL 23 '58	24b. REGISTRAR'S SIGNATURE <i>Asheville</i>



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07823

7827 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Carroll		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Hampstead-Rural		Carroll	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
10 yrs		Hampstead, Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
✓		✓	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
MARY - IDELLA HARRIS			
4. SEX	5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. B. DATE OF BIRTH
M	W	WIDOWED <input checked="" type="checkbox"/>	Sept 2-1874
8. DIVORCED <input type="checkbox"/>		9. AGE in years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday Months Days Hours Min.	
		83	7 17 00 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired		Housework	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Md		USA	
13. FATHER'S NAME		14. MOTHER'S M AIDEN NAME	
George album		Emma Baulbly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.	
No		769-10-1000	
17. INFORMANT		Address	
Geo. Hens. Hampstead Md. P.S.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 week	
DUE TO		Cerebral Thrombosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Cerebral Arterio-sclerosis 6-8 yrs	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
		Hampstead, Md. Carroll, Md. Md.	
21. I certify that I attended the deceased from 7-10, 1958 to 7-17, 1958, that I last saw the deceased alive on 7-17, 1958, and that death occurred at 7:20 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
M.C. Porterfield		Hampstead, Md. Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
M.C. Porterfield		7/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial July 1958		22c. NAME OF CEMETERY OR CREMATORIAL	
		St. Mary's Cemetery	
22d. LOCATION (City, town, or county)		(State)	
New York City		N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. ADDRESS	
Edgar Tipton, Hampstead Md.		Edgar Tipton, Hampstead Md.	
24b. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUL 22 '58		Alice C. Smith	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for the burial permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

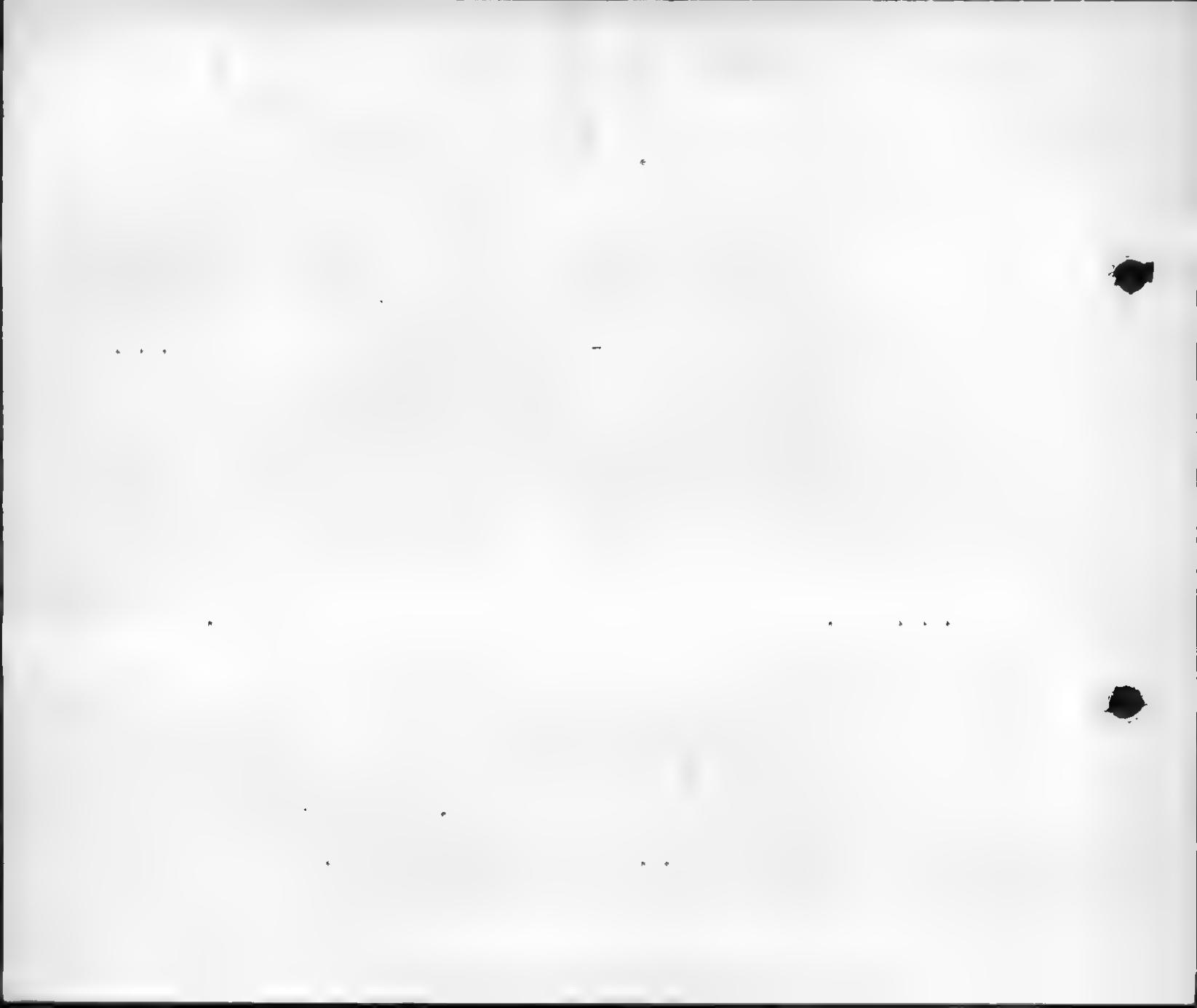
7828

CERTIFICATE OF DEATH

07824

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Sykesville		c. LENGTH OF STAY IN 1b 5 mos. 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Taneytown		d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Robertson	Last Hively	4. DATE OF DEATH July	Month 27	Day 19	Year 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 13, 1896	9. AGE (In years lost birthday) 62 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY OWN HOME	12. BIRTHPLACE (State or foreign country) Maryland	13. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Robertson				14. MOTHER'S MAIDEN NAME Medora Barnes					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO - - -		17. INFORMANT Springfield Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> INTERVAL BETWEEN ONSET AND DEATH Days									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. L.T.A		(b) DUE TO							
		(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with presenile brain disease with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) WESTMINSTER	(County) MD	(State) MD
21. I certify that I attended the deceased from <u>February 22, 1958</u> to <u>July 27, 1958</u> , that I last saw the deceased alive on <u>July 27, 1958</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 7/28/58									
PHYSICIAN'S NAME (Type)		Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/30/58		22c. NAME OF CEMETERY OR CREMATORIUM MEADOW BRANCH		22d. LOCATION (City, town, or county) WESTMINSTER		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Dr Hartley & Son New Windsor		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 30 '58		24b. REGISTRAR'S SIGNATURE Albert Smith			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
7829 CERTIFICATE OF DEATH													
Reg. Dist. No. 07825													
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5mos. 13days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2740 Maryland Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Addie	Middle Ward	last Holland	4. DATE OF DEATH July 14, 1958	Month July	Day 14	Year 1958					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1886	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland					
13. FATHER'S NAME James Ward				14. MOTHER'S MAIDEN NAME Mary Riggan				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Branchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertensive cardiovascular disease (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) January 31, 1958									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital		20f. (City or town) Springfield		(County) Wicomico		(State) Md.	
21. I certify that I attended the deceased from January 31, 1958 to July 14, 1958 , that I last saw the deceased alive on July 14, 1958 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 7/15/58													
ACTUAL SIGNATURE Edmund Lusthaus, M.D.				PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery				22d. LOCATION (City, town, or county) Crisfield, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				ADDRESS Bradsaw & Sons, Crisfield, Md.				24a. REC'D BY REGISTRAR DATE JUL 21 '58		24b. REGISTRAR'S SIGNATURE Alfred Leach			

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may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, please remove carbon copy. Lines 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

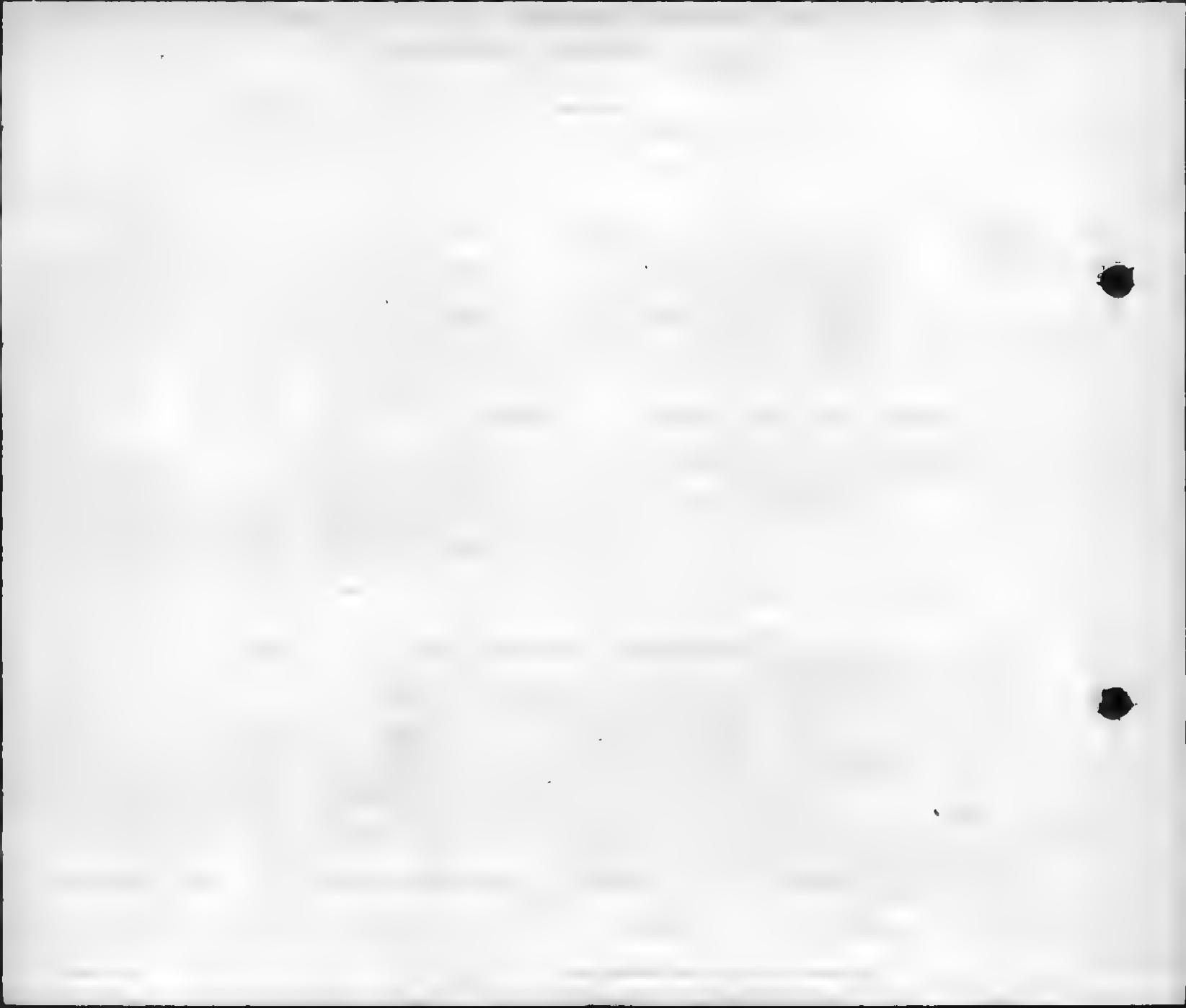
07826

7830

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.		b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WESTMINSTER		c. LENGTH OF STAY IN 1b 30 YR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WESTMINSTER		d. STREET ADDRESS RP 5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RP 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) INEZ CULLISON HORINE		First	Middle	Last	4. DATE OF DEATH JULY 23 1958	Month	Day	Year	
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 21, 1909 46		9. AGE (In years last birthday) 46 yrs	10. IF UNDER 1 YEAR Months . Days . Hours . Min .		11. IF UNDER 24 HRS. Months . Days . Hours . Min .	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHESTER CULLISON		14. MOTHER'S MAIDEN NAME NANNIE GREEN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-20-8335		17. INFORMANT RALPH A. HORINE WESTMINSTER	Address RP 5
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary Thrombosis		Coronary Sclerosis		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH Several hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Obesity & mild hypertension		Obesity & mild hypertension		Obesity & mild hypertension		INTERVAL BETWEEN ONSET AND DEATH Several yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) MD.		(County) MD.	(State) MD.
21. I certify that I attended the deceased from July 19, 1958 to July 23, 1958 , that I last saw the deceased alive on July 19, 1958 and that death occurred at 7:45 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Westminster, MD		DATE SIGNED 7/24/58					
ACTUAL SIGNATURE W. L. Cullison		PHYSICIAN'S NAME (Type) W. L. Cullison							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-26-1958		22c. NAME OF CEMETERY OR CREMATORIAL MEADOW BRANCH CEM. WESTMINSTER		22d. LOCATION (City, town, or county) MD.		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David A. Barbara		ADDRESS Westminster, MD.		24a. REC'D BY REGISTRAR DATE JUL 28 '58		24b. REGISTRAR'S SIGNATURE Act. each			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

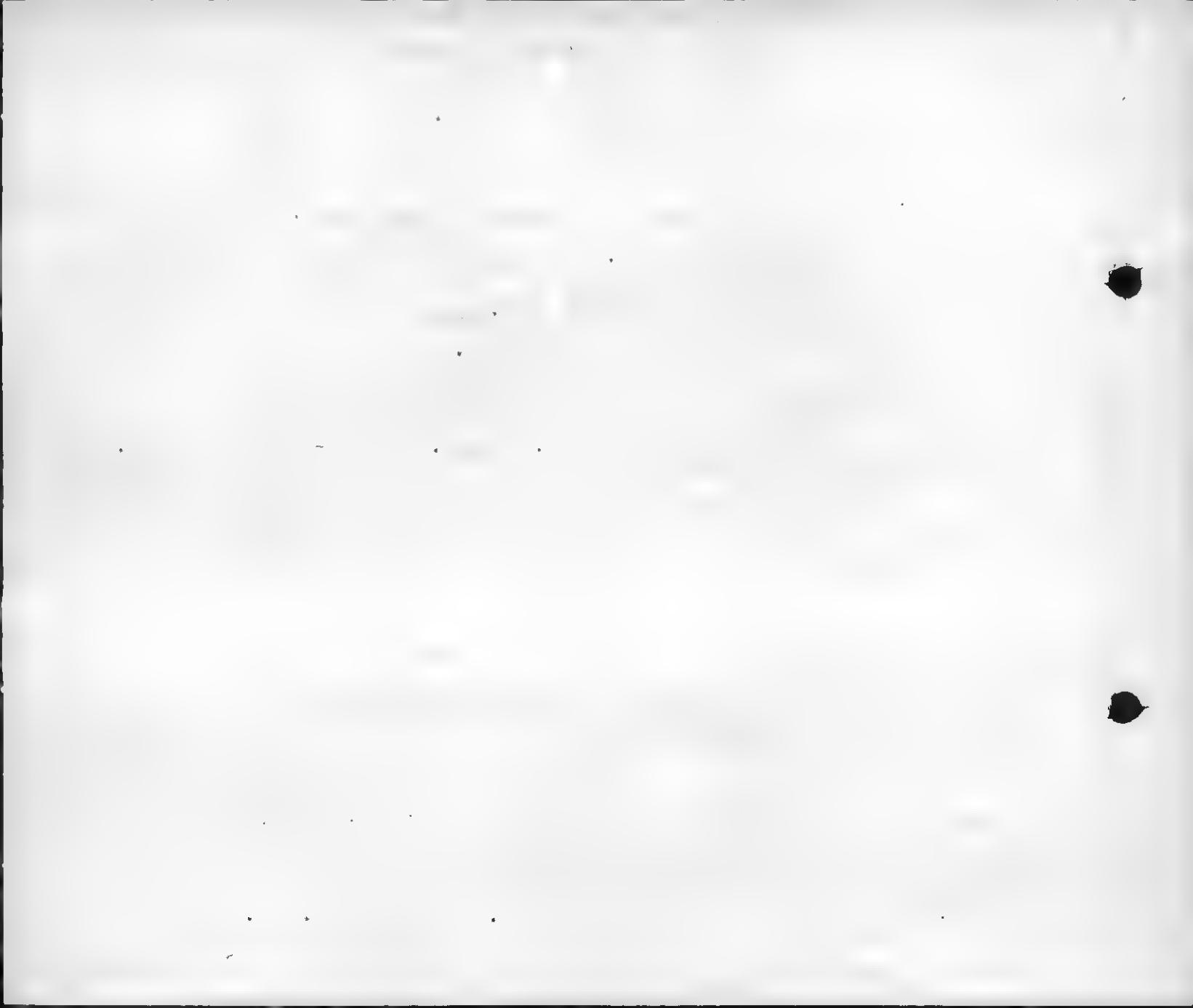
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 3, and in my event within 72 hours after death, file in my registrar prior to burial, cremation, or removal, and in my event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7831 CERTIFICATE OF DEATH

07827
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eldersburg</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>2537 Woodbrook Ave.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grand View Nursing Home</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MARIE</i>		First <i>MARIE</i>	Middle <i>D.</i>	Lost <i>HORNUNG</i>	4. DATE OF DEATH <i>Feb. 9, 1897</i>	Month <i>July</i>	Day <i>28</i>	Year <i>1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 9, 1897</i>	9. AGE (in years from birthday) <i>61 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. HOURS Hours <i>0</i>	13. MIN <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper (Rtd)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wholesale Jewelry</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Wilhelm Hornung</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Mueller</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Henry P. Hornung - 3721 Marmon Ave.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malaria - a chronic disease</i>									
110X DUE TO <i>Various diseases due to malaria</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Various diseases due to malaria</i>									
DUE TO (c) <i>Caused death</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Oct. 1, 1957</i> , to <i>Feb. 9, 1958</i> , that I last saw the deceased alive on <i>July 25, 1957</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE: <i>J. C. Darby</i>						ADDRESS (Street, city or town, state) <i>M.D. 312 Medical Hill Rd.</i>		DATE SIGNED <i>July 31, 1958</i>	
PHYSICIAN'S NAME (Type) <i>W.A. Darby</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/30/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Tichner & Sons - Baltimore, Md.</i>		ADDRESS <i>17 N. E. 17th St.</i>		24a. REC'D BY REGISTRAR DATE JUL 31 '58		24b. REGISTRAR'S SIGNATURE <i>Albert Reich</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7832

CERTIFICATE OF DEATH

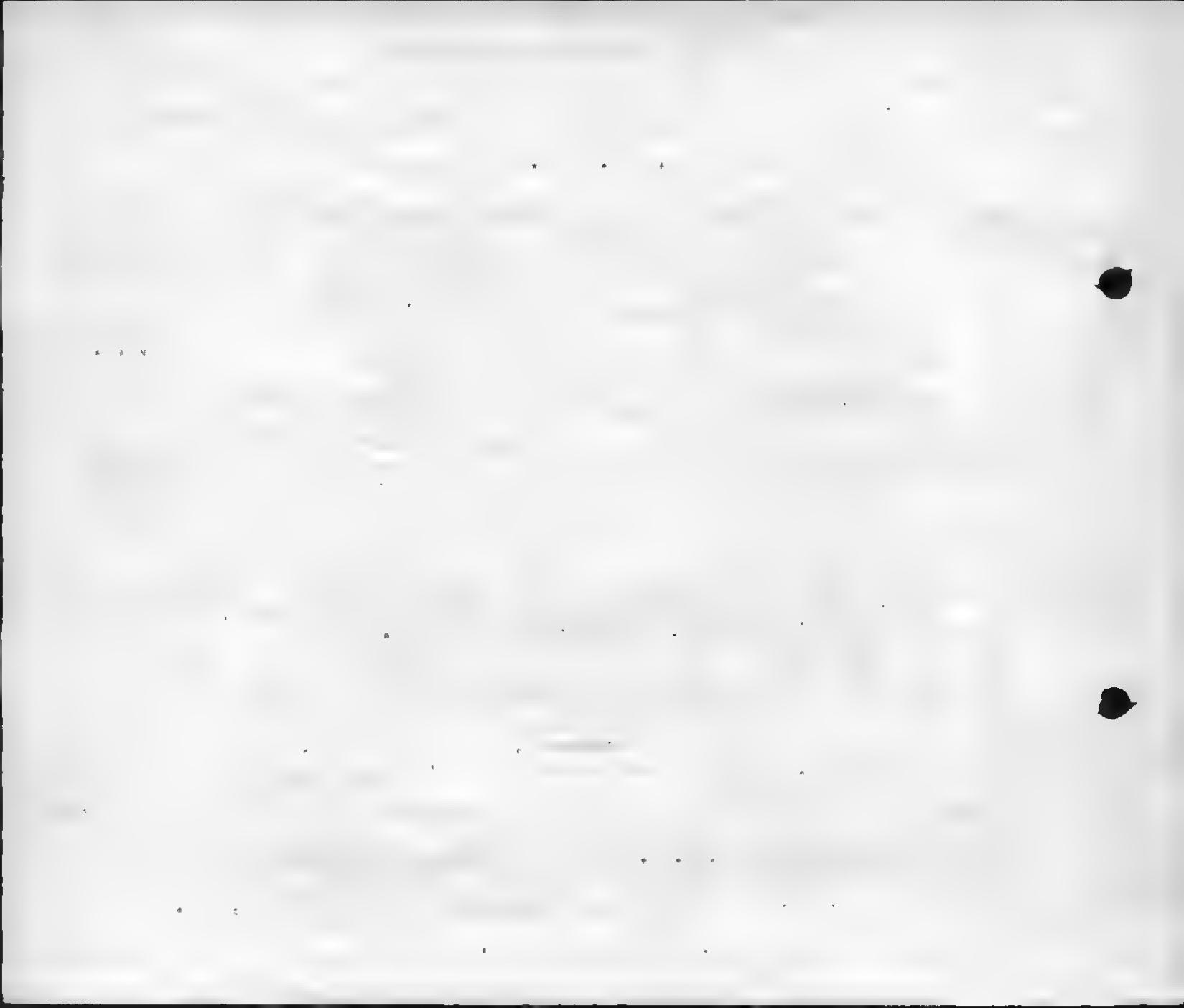
07828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)		c. LENGTH OF STAY IN 1b 1 y. 7 m. 20 d.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 123 Greenmount Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anna	Middle Matilda	Last Jennings	4. DATE OF DEATH July 28 1958	Month July	Day 28	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 19, 1880	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 77 yrs	Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Edward Fry			14. MOTHER'S MAIDEN NAME Mary Margaret Goodman			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield State Hospital Record					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute + Chronic Myocardial Infarction DUE TO Arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Carcinoma of colon									
INTERVAL BETWEEN ONSET AND DEATH minutes years months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)							
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. 19 <input type="checkbox"/> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Brownsville, Md.		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from December 8, 1956 , to July 28, 1958 , that I last saw the deceased alive on July 28, 1958 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Elizabeth Knopp									DATE SIGNED 7/29/58
PHYSICIAN'S NAME (Type) Elizabeth Knopp, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-31-58		22c. NAME OF CEMETERY OR CREMATORIUM Episcopal Cemetery		22d. LOCATION (City, town, or county) Brownsville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home, Hagerstown, Md.									
ADDRESS Minnich Funeral Home, Hagerstown, Md.									
24a. REC'D BY REGISTRAR DATE JUL 31 '58									
24b. REGISTRAR'S SIGNATURE Albrecht									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7833

Item 1 F 1 1/231 7-21-58 et

07829

Reg. Dist. No.

1. PLACE OF DEATH
o COUNTY

CARROLL

MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
o STATE Maryland b COUNTY Baltimore Co.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Sykesville

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Springfield State Hospital Admitting Office 2915 Cornwall Road

3. NAME OF
DECEASED
(Type or print)

First
ANNIE

Middle
MARIA

Last
KILPATRICK

4. DATE
OF
DEATH

Month
7

Day
11
Year
1958

5. SEX

Female W

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

7/21/64

9. AGE (in years
for birthday)

93

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

housewife

West Virginia

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME

George Bradshaw

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO

none

17. INFORMANT

Charles C. Kilpatrick, 7319 Betz Avenue, Baltimore-19, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4/20/1

DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Arteriosclerotic cardiovascular disease with
decompensation.

Years

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AN AUTOPSY
PERFORMED?

YES NO

20. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. ————— 19
p. m. —————

20d. INJURY OCCURRED
While of work Not while of work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

James T. Marsh, M.D.

DATE SIGNED

7/11/58

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION, OR
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7/12/58

22c. NAME OF CEMETERY OR CREMATORIUM

Greenhill Cemetery

22d. LOCATION (City, town, or county)

Martinsburg, West Virginia

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

William Cook - Elight, Inc

ADDRESS

6009 Marford Road

24a. REC'D BY REGISTRAR

JUL 14 1958

24b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director. Page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

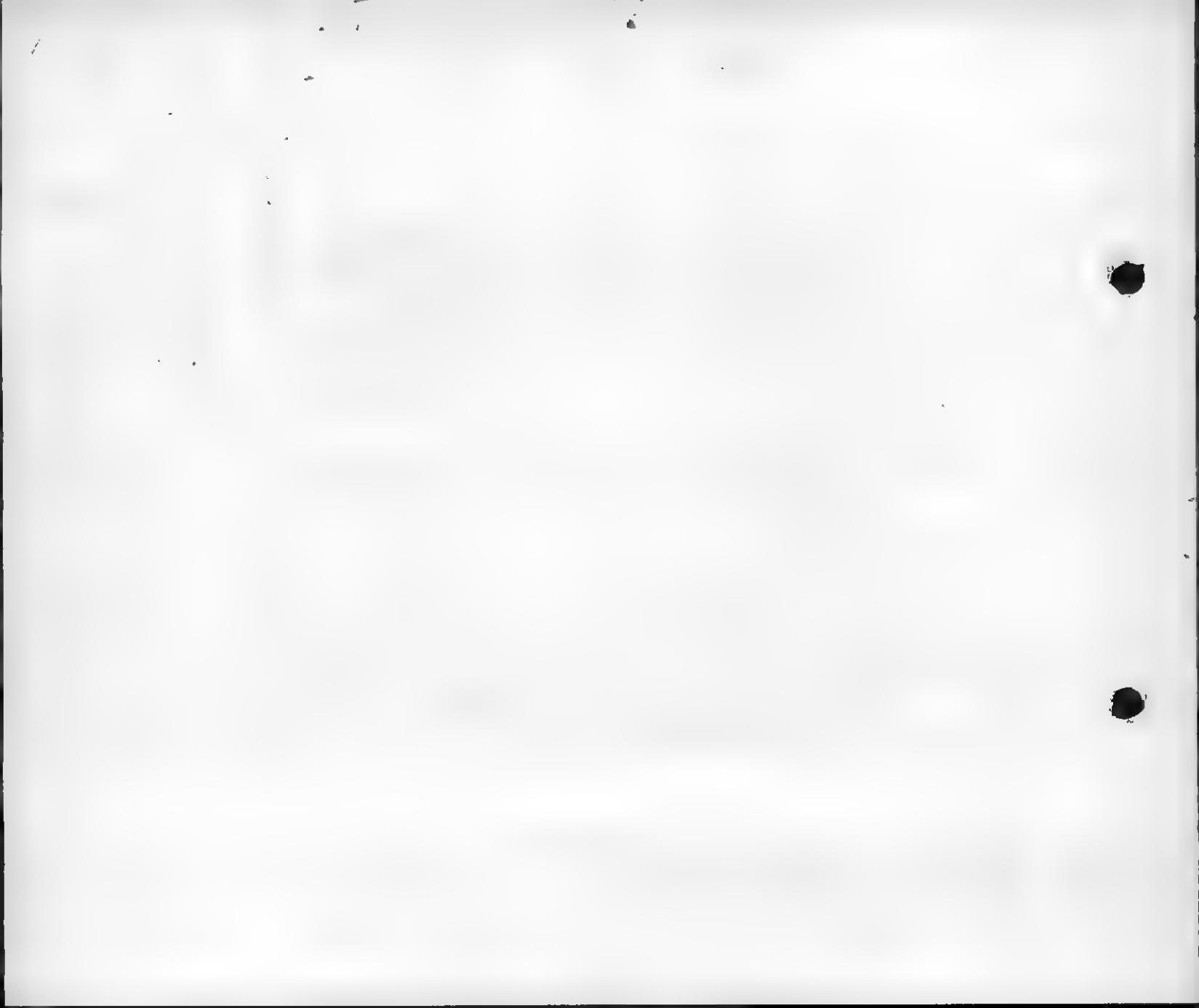
7834

CERTIFICATE OF DEATH

07830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Roland		First William	Middle Koons
4. DATE OF DEATH July 1 1958		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1893	
9. AGE (In years last birthday) 65 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Addison Koons		14. MOTHER'S MAIDEN NAME Emma Jane Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 13-36-3432	
17. INFORMANT Mrs. Carrie Koons, 5000 Taneytown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 18/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Basal Cerebral Hemorrhage 6 hrs INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-30-1958, to 7-1-1958, that I last saw the deceased alive on 7-1-1958, and that death occurred at 7:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. N. Legg M.D. PHYSICIAN'S NAME (Type) T. H. Legg M.D. ADDRESS (Street, city or town, state) Union Bridge Md-7-1-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/3/58	
22c. NAME OF CEMETERY OR CREMATORIAL Keysville Cemetery		22d. LOCATION (City, town, or county) Keysville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Morgan C. Fuss, Son		24a. ADDRESS Taneytown, Md.	
24b. REC'D BY REGISTRAR DATE JUL 3 '58		24c. REGISTRAR'S SIGNATURE Albert J. Smith	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the funeral director. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

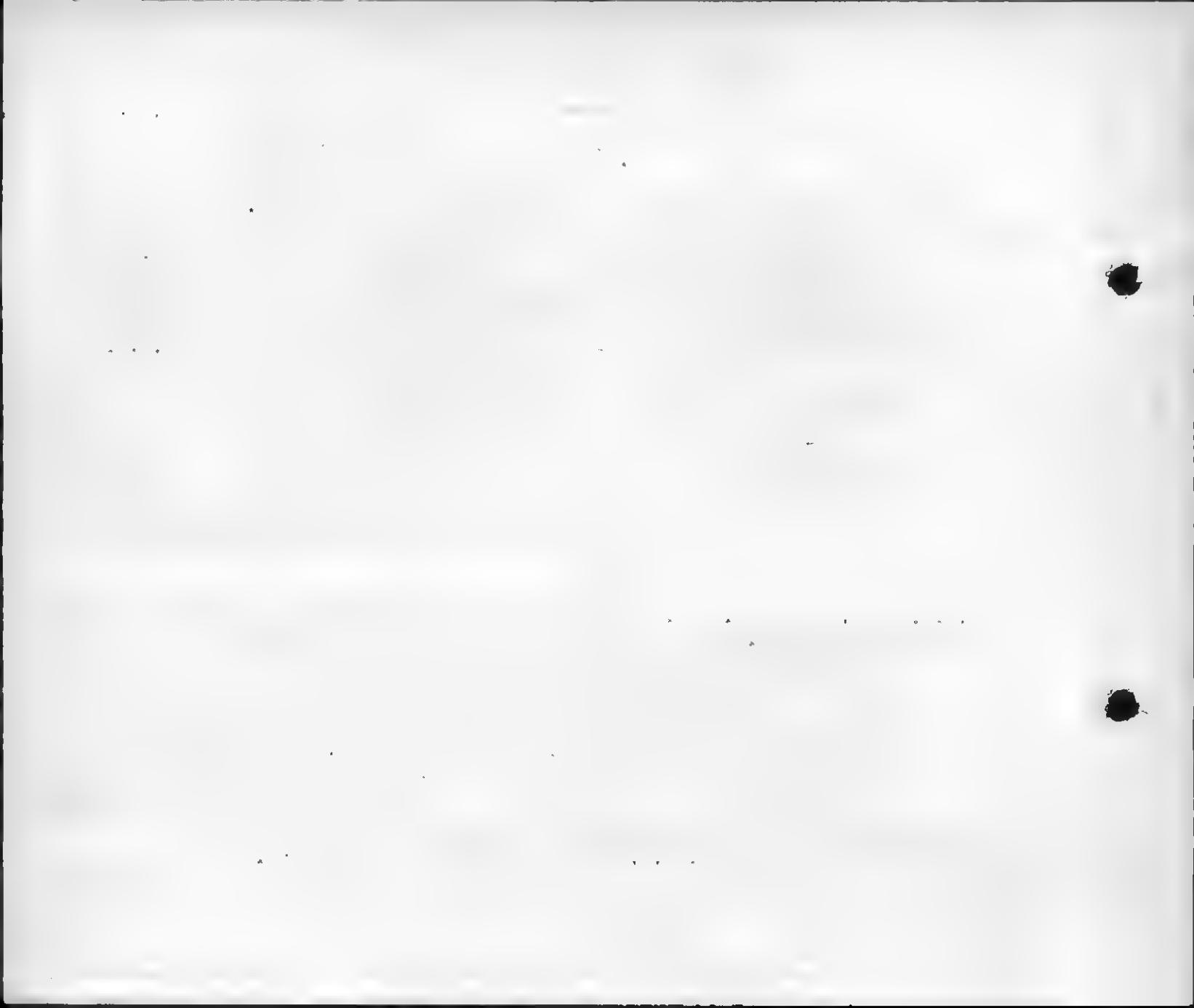
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07831

CERTIFICATE OF DEATH

Reg. Dist. No.

7835		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
a. COUNTY Carroll		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 mos. 26 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2706 Hamilton Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Louise	Last Barwick LAUMANN
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Barwick	14. MOTHER'S MAIDEN NAME Anne Phipps		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X not due to			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) due to			
C. B. S. assoc. with circ. dist. other than cerebral arteriosclerosis, with (c) Psychotic reaction, Hypertensive cardiovascular disease Generalized Arterosclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 21, 1958, to July 17, 1958, that I last saw the deceased alive on July 17, 1958, and that death occurred at 11:40A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/17/58		
PHYSICIAN'S NAME (Type)	Sykesville, Maryland.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY 21, 1958	22c. NAME OF CEMETERY OR CREMATORIUM SCHWARTZ CEMETERY	22d. LOCATION (City, town, or county) BALTIMORE (State) MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Son's Lewison & Judd.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 21 '58	24b. REGISTRAR'S SIGNATURE Ab. Leach



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

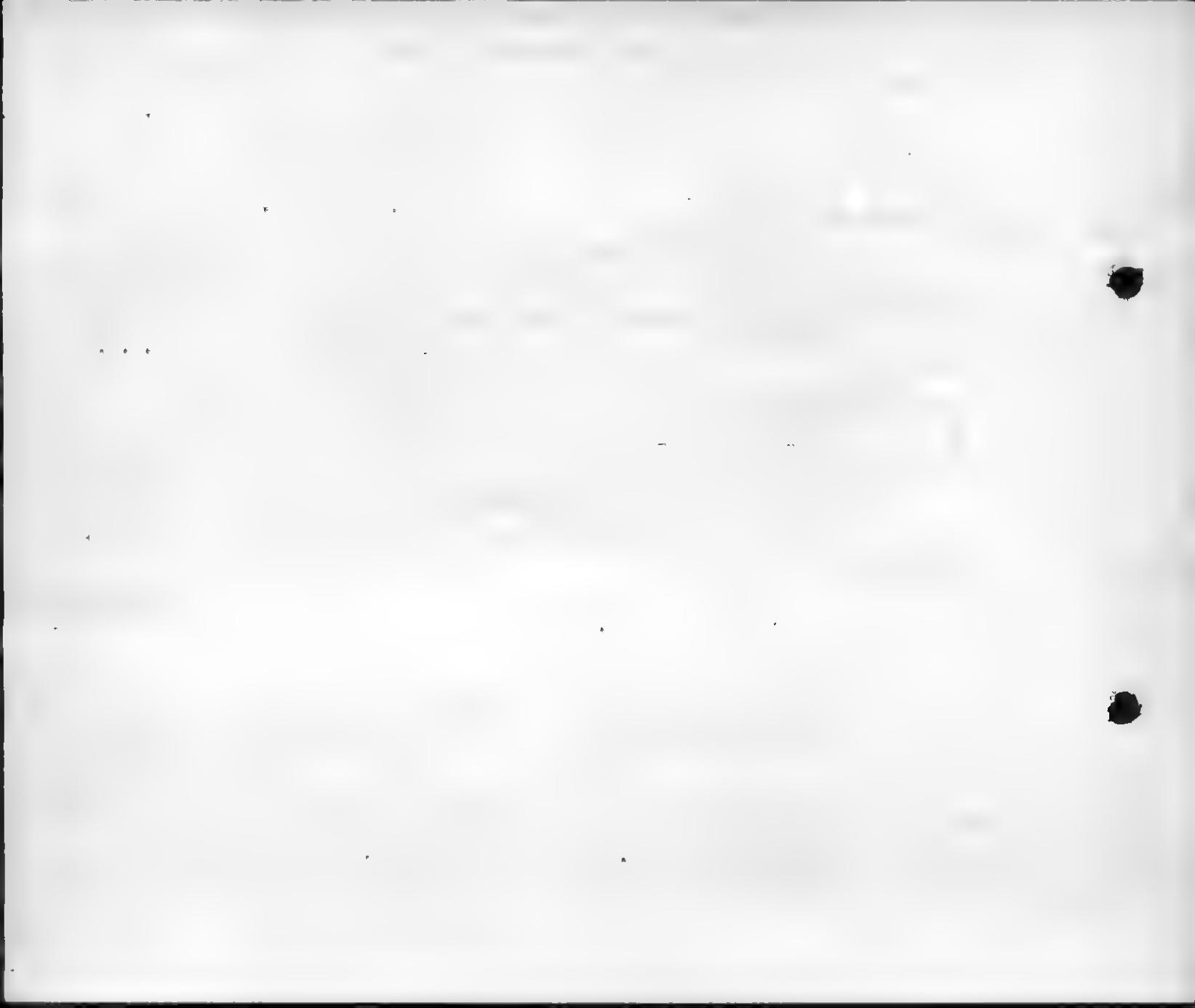
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 20 days		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1647 E. North Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kathleen	Middle Jean	Last McDonnell	4. DATE OF DEATH July 20, 1958	Month July	Day 20	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 19, 1900	9. AGE (In years at birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY =		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael McDonnell		14. MOTHER'S MAIDEN NAME Mary Kelly							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. =		17. INFORMANT Springfield State Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Arteriolar nephrosclerosis		INTERVAL BETWEEN ONSET AND DEATH Weeks					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease		DUE TO Arteriosclerotic heart disease		Years.					
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Involutional psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I attended the deceased from June 30, 1958, to July 20, 1958, that I last saw the deceased alive on July 20, 1958, and that death occurred at 9:40 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Springfield State Hospital					
ACTUAL SIGNATURE Edmund Lusthaus PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				DATE SIGNED 7/21/58					
22a. BURIAL, CREMATION ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/1958		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery		22d. LOCATION (City, town, or county) Baltimore			(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Annacost		4600 Liberty Hghts. Ave		24a. REC'D BY REGISTRAR DATE JUL 28 '58		24b. REGISTRAR'S SIGNATURE A. L. Smith			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7836

CERTIFICATE OF DEATH

07833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>York</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN lb <i>3 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover Pa</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR/INSTITUTION <i>Long Circle Nursing Home.</i>		d. STREET ADDRESS <i>109 W. Franklin St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>7</i>	Middle <i>feber</i>	Last <i>Michael</i>	4. DATE OF DEATH <i>July 1, 1958</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 7, 1874</i>	9. AGE (In years lost birthday) <i>86 yrs</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mens Clothes</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Samuel Michael</i>		14. MOTHER'S MAIDEN NAME <i>Angeline Allright</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>W. Ward Michael Hanover Pa</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i>		DUE TO <i>Diabetes</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Right & left foot 2 mo.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Diabetes Mellitus</i>		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Artherosclerosis</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	Month <i>July</i>	Day <i>11</i>	Year <i>1958</i>		
21. I certify that I attended the deceased from <i>July 12, 1958</i> , to <i>July 11, 1958</i> , that I last saw the deceased alive on <i>July 1, 1958</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Joseph E. Bush M.D.</i>		PHYSICIAN'S NAME (Type) <i>Joseph E. Bush M.D. / Hampstead, Maryland 1958</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-4-1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>	22d. LOCATION (City, town, or county) <i>Hanover, Pa.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dennis R. D. Wetzel</i>	ADDRESS <i>549 Carlisle St. Hanover, Pa.</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 7 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Deborah</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and camped, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07834

CERTIFICATE OF DEATH

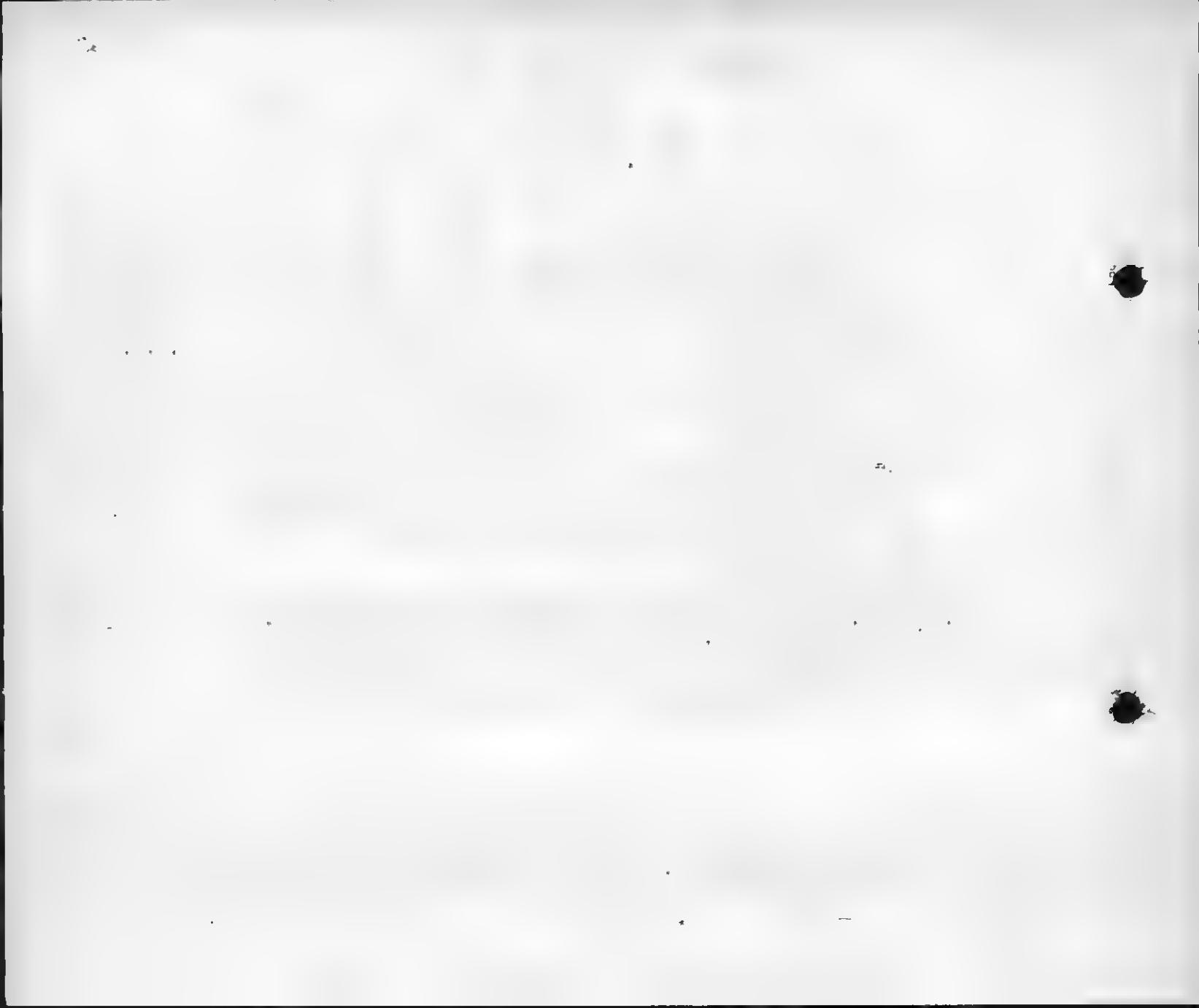
Reg. Dist. No.

7837

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 4 mos. 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS Manor Lane	
3. NAME OF DECEASED (Type or print)	First Lola	Middle May	Last Sherman
4. DATE OF DEATH	Month July	Day 31	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1889
9. AGE (In years less birthday) yrs 68	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY -	12. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME Thomas Sherman	14. MOTHER'S MAIDEN NAME Mary Jane Everets		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No	16. SOCIAL SECURITY NO -	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Rheumatic valvulitis inactive (with deformity due to mitral valve)			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic heart disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Paget's disease of bone.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1958 , to July 31, 1958 , that I last saw the deceased alive on July 30, 1958 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 7/31/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-58	22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Lutheran
22d. LOCATION (City, town, or county) Pfeifers Corner, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HC Huguenot, Ellicott City, Md</i>		24a. REC'D BY REGISTRAR DATE AUG 4 '58	24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO **FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

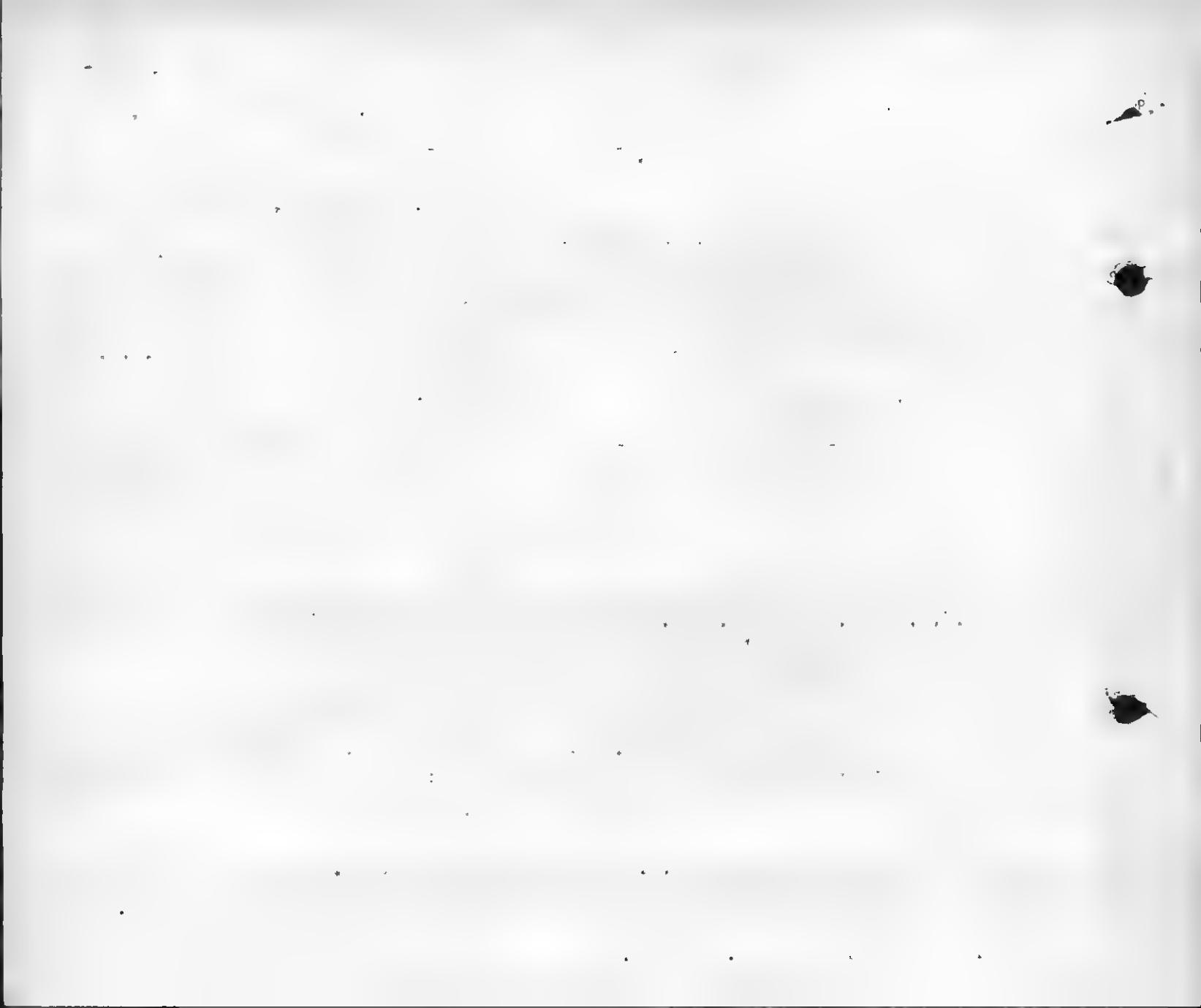
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7838

CERTIFICATE OF DEATH

Reg. Dist. No. 17835

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE [Where deceased lived if institution: Residence before admission] a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 7mos. 21days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mabel Edith Finch	Middle MURPHY	4. DATE OF DEATH July 7, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1872
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac B. Finch		14. MOTHER'S MAIDEN NAME Eliza Bare	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brachopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 16, 1958 , to July 7, 1958 , that I last saw the deceased alive on July 7, 1958 , and that death occurred at 7:25PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edmund Lusthaus, M.D. Springfield Hospital DATE SIGNED 7/8/58			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMAVAL (Specify) Burial		22b. DATE THEREOF July 11, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore		22d. LOCATION (City, town, or county) Baltimore (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.	
24a. REC'D BY REGISTRAR Jul 10 '58		24b. REGISTRAR'S SIGNATURE A. L. Cook	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

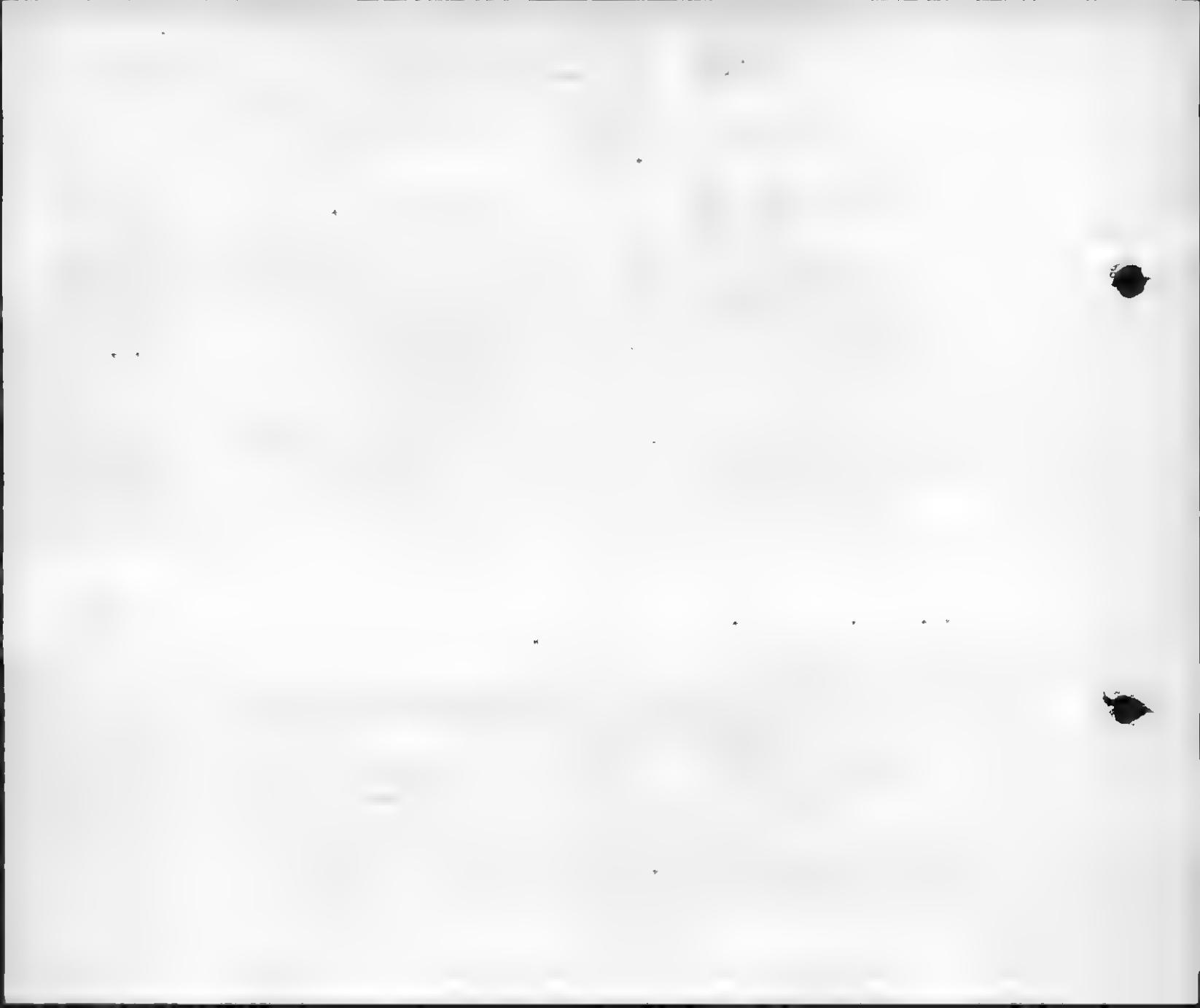
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7839

CERTIFICATE OF DEATH

Reg. Dist. No 7836

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 10mos. 9days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 9628 Dilston Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Helen	Middle Hard	Last Nelson
4. DATE OF DEATH	Month July	Day 13,	Year 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1880
9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS Days —	12. IF UNDER 24 HRS Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Hard	14. MOTHER'S MAIDEN NAME Isabel Dunn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 491-1	17. INFORMANT Uncle	Address Springfield Hospital Records.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
19. INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) brain disease with psychotic reaction.		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 4, 1957 , to July 13, 1958 , that I last saw the deceased alive on July 13, 1958 , and that death occurred at 4:53 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 7/14/58			
PHYSICIAN'S NAME (Type)	Sykesville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify Cemetery, 7-21-58)	22b. DATE THEREOF 7-21-58	22c. NAME OF CEMETERY OR CREMATORIAL Sykesville Memorial Park, Sykesville, Md.	22d. LOCATION (City, town, or county) Long Beach, Cal.
23. FUNERAL DIRECTOR'S SIGNATURE Franklin A. Haigd, Sykesville, Md.	ADDRESS Franklin A. Haigd, Sykesville, Md.	24a. REC'D BY REGISTRAR DATE JUL 21 '58	24b. REGISTRAR'S SIGNATURE Albert L. Souch



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7840

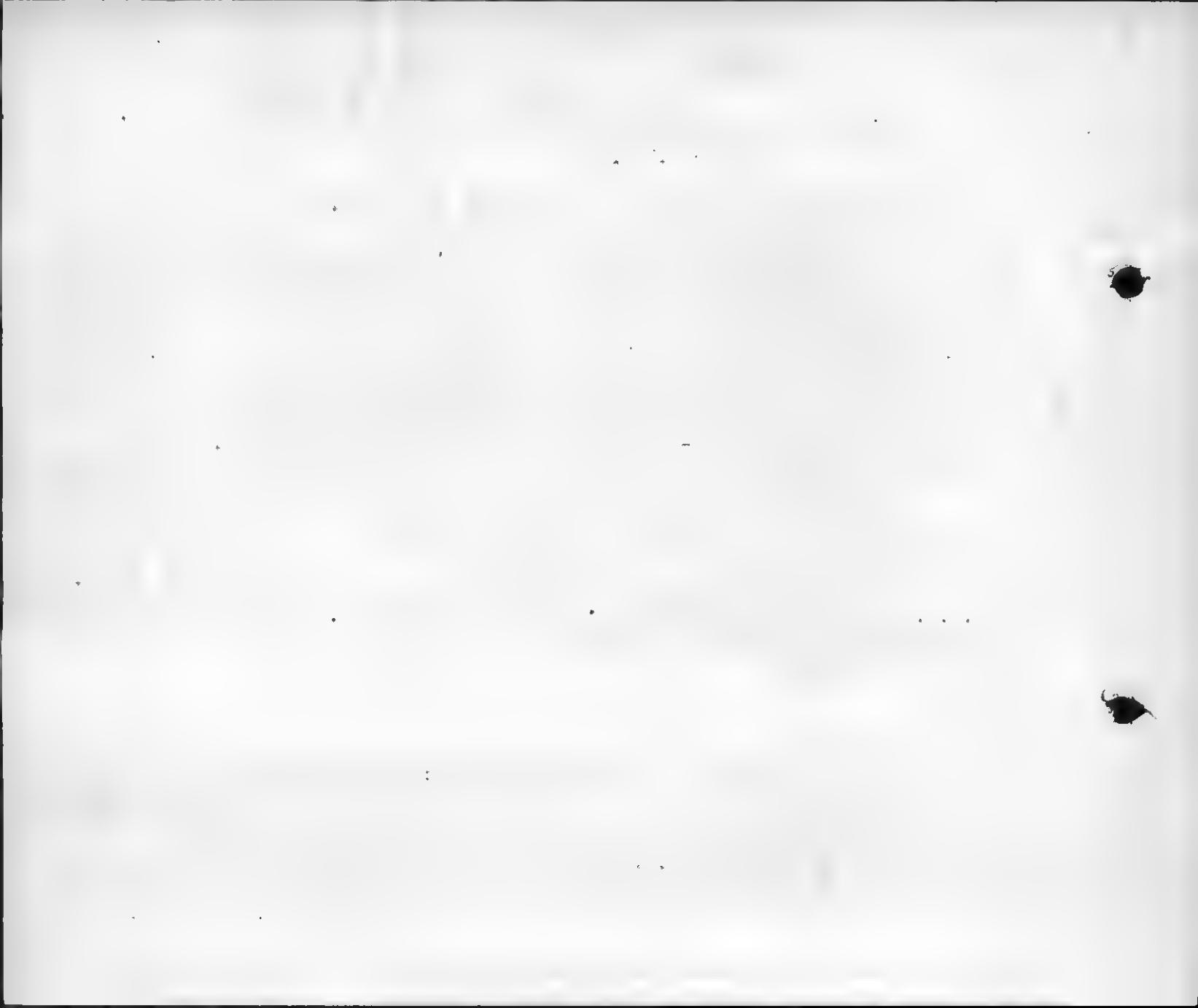
CERTIFICATE OF DEATH

Reg. Dist. No.

07837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 yrs, 1 mo, 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Frank		d. STREET ADDRESS 3600 Ailsa Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Last NOYA, Sr. Month July Day 17, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1875
9. AGE (In years last birthday) 83 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman	11. KIND OF BUSINESS OR INDUSTRY -	12. BIRTHPLACE (State or foreign country) Spain
13. FATHER'S NAME Ramon Noya	14. MOTHER'S MAIDEN NAME Josephine Naveira	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Branchpneumonia INTERVAL BETWEEN ONSET AND DEATH Days			
Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last (b) Arteriosclerotic heart disease Years			
(c) Generalized arteriosclerosis Years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. with senile brain disease with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955, to July 17, 1958, that I last saw the deceased alive on July 16, 1958, and that death occurred at 12:05 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustín del Campo</i>		ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 7/17/58	
PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/58	22c. NAME OF CEMETERY OR CREMATORIUM Evergreen
22d. LOCATION (City, town, or county) Essex Co.		(State) N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. 5305 Harford Rd.		24a. REC'D BY REGISTRAR DATE JUL 21 '58	24b. REGISTRAR'S SIGNATURE <i>Albert J. Ruck</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07838

7841

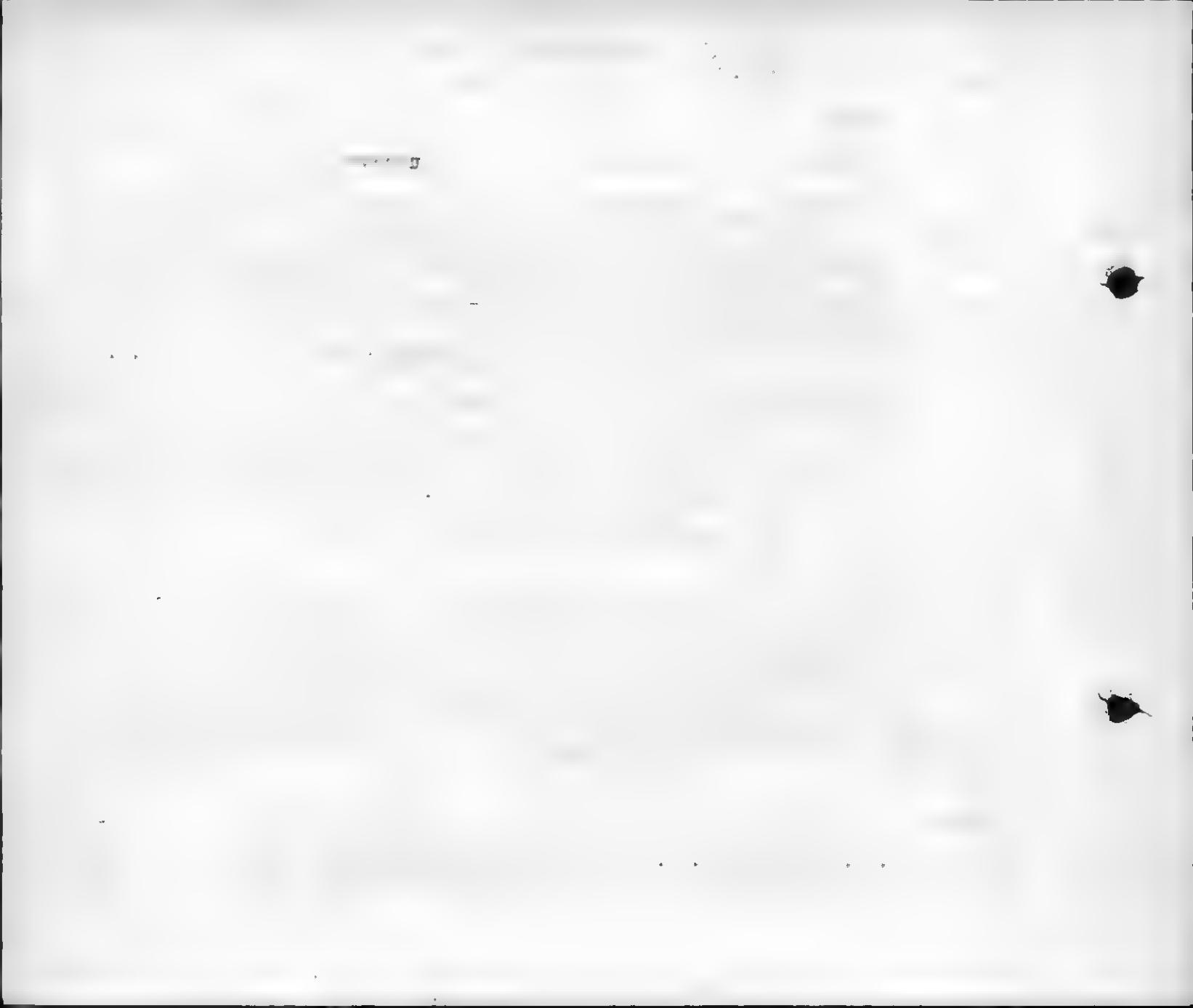
CERTIFICATE OF DEATH

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 249 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		d. STREET ADDRESS Churchton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Emory		First Emory	Middle Richard	last Offer	4. DATE OF DEATH July 20 1958	Month July	Day 20	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1898	9. AGE (In years from birthdate) 60 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Churchton, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A?			
13. FATHER'S NAME Richard Offer		14. MOTHER'S MAIDEN NAME Mary Brooks							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Florida Offer - Churchton, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary Tbc. left with pleurisy						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Suspected tumor									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Florida Offer - Churchton, Maryland		(County) Florida	(State) Florida
21. I certify that I attended the deceased from November 13, 1957 , to July 20, 1958 , that I last saw the deceased alive on July 20, 1958 , and that death occurred at 11:45 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Florida Offer - Churchton, Maryland		DATE SIGNED 7-20-58	
ACTUAL SIGNATURE <i>E. M. Maculans M.D.</i>									
PHYSICIAN'S NAME (Type) E. M. Maculans, M. D.				Henryton State Hospital					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-58		22c. NAME OF CEMETERY OR CREMATORIAL St. Matthew's Cemetery		22d. LOCATION (City, town, or county) Florida		(State) Florida	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Maculans #2</i>		ADDRESS 101 Henryton St.		24a. REC'D BY REGISTRAR July 25, 1958		24b. REGISTRAR'S SIGNATURE <i>John J. Maculans</i>			



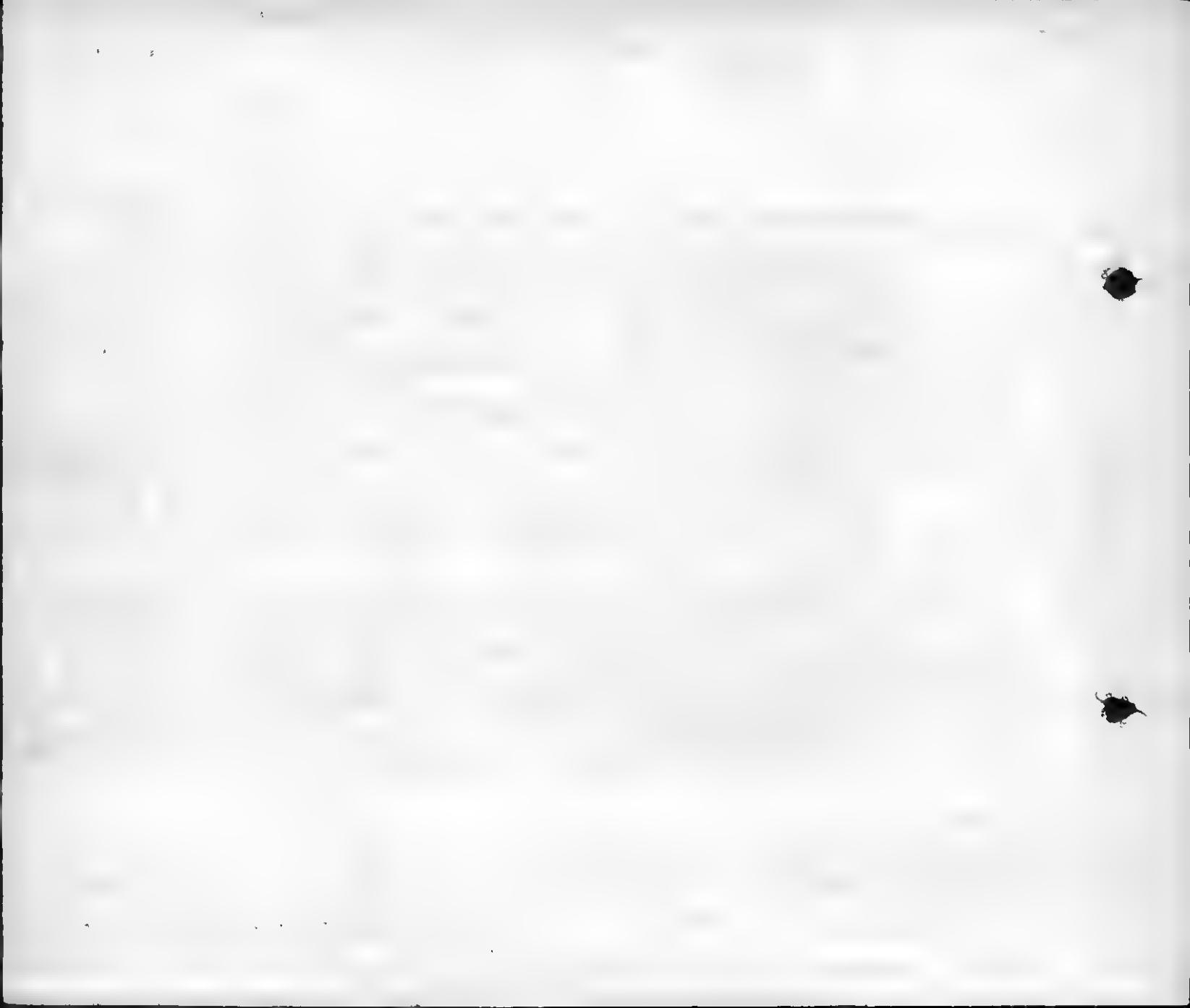
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07839

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY CARROLL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 81 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		d. STREET ADDRESS 49 CHURCH		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 CHURCH				d. STREET ADDRESS 49 CHURCH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) SARAH PAULINE		First	Middle	Last	4. DATE OF DEATH JULY 26 1958	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 29 1877		9. AGE (In years last birthday) 81 yrs.	11. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ROSETTIE FRIZZELL		14. MOTHER'S MAIDEN NAME MARY J. BELL						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT None		Address 49 CHURCH WESTMINSTER MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. (b) DUE TO A.S.C.V. DISEASE (c)						INTERVAL BETWEEN ONSET AND DEATH 8 days		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 105 E Main		(County) (State) WESTMINSTER
21. I certify that I attended the deceased from 7-18-58 , 19 58 , to 7-26 , 19 58 , that I last saw the deceased alive on 7-16 , 19 58 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) WESTMINSTER		
ACTUAL SIGNATURE JAMES T. MARSH		PHYSICIAN'S NAME (Type) JAMES T. MARSH		M.D.		DATE SIGNED 7/28/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 30/58		22c. NAME OF CEMETERY OR CREMATORIUM WESTMINSTER CEM.		22d. LOCATION (City, town, or county) WESTMINSTER N.D.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE James T. Marsh		ADDRESS 105 E Main		24a. REC'D BY REGISTRAR DATE AUG 4 '58		24b. REGISTRAR'S SIGNATURE Westminister		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7842

CERTIFICATE OF DEATH

07840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 3 yrs. 7 mos. 20 days Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS 3120 Keswick Road	
3. NAME OF (Type or print)	First Michael	Middle -	4. DATE OF DEATH July 29 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Phillip O'Shea	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 220-05-5129	17. INFORMANT Records of Springfield State Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 X1000 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Suppurative nephritis DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH years unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with circulatory disturbance, with cere- bral arteriosclerosis, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18] -	
20c. TIME OF INJURY Hour a. m. - p. m. -	Month Doy. Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -
20f. (City or town) -	(County) -	(State) -	
21. I certify that I attended the deceased from Aug. 1955, to July 29, 1958, that I last saw the deceased alive on July 29, 1958, and that death occurred at 10:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADRESSEES (Street, city or town, state) DATE SIGNED 7/29/58			
ACTUAL SIGNATURE Walter Knopp, M. D.	PHYSICIAN'S NAME (Type) Walter Knopp, M. D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 8/1958	22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Pk.	22d. LOCATION (City, town, or county) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Scott		ADDRESS 814 W 36th St	24a. REC'D BY REGISTRAR DATE JUL 31 '58
			24b. REGISTRAR'S SIGNATURE Audrey

1. **DEATH CERTIFICATE**: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

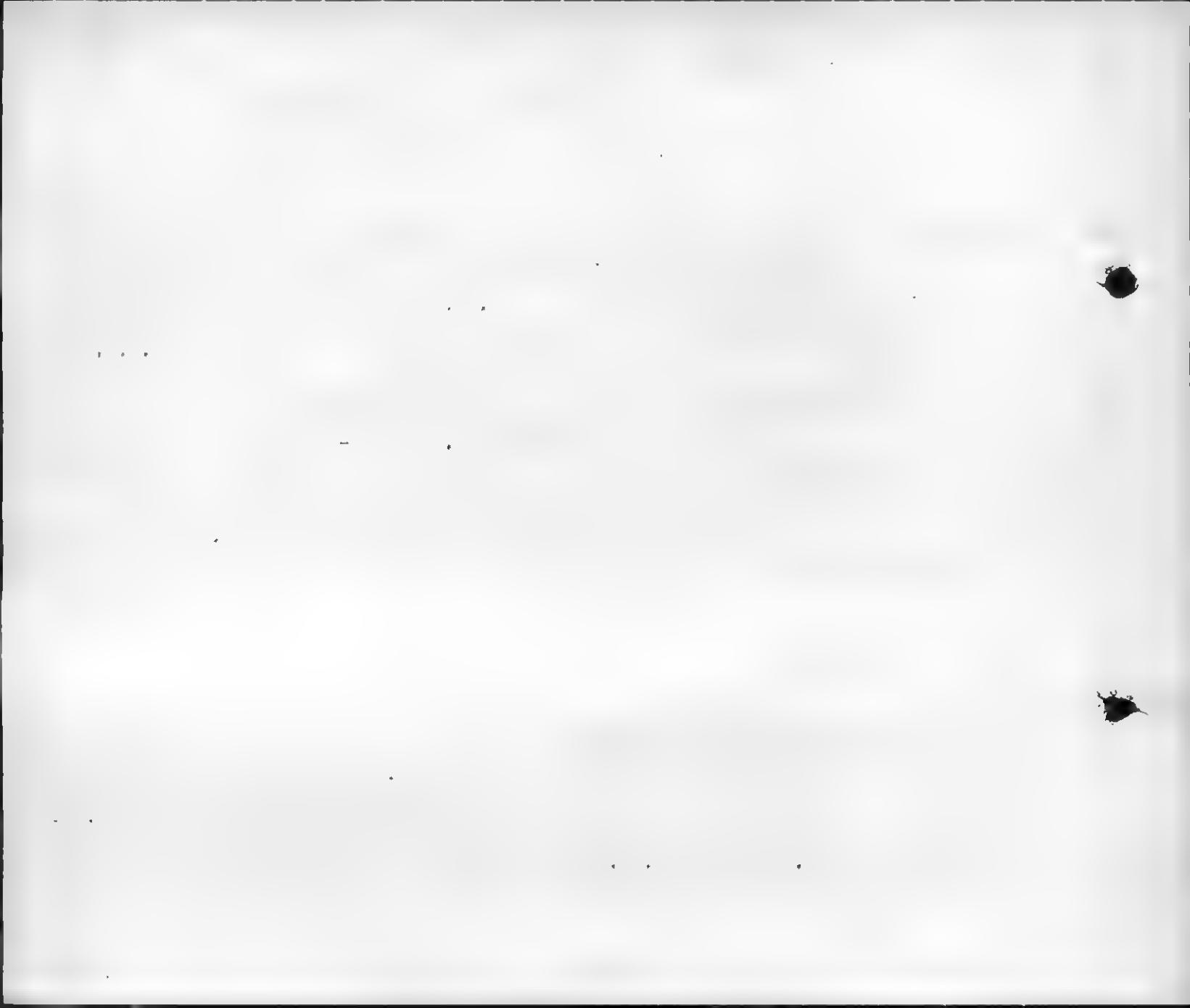
7843

CERTIFICATE OF DEATH

07841

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 95 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha	First	Middle	Last
4. DATE OF DEATH July 13	Month	Day	Year 1958
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1901
9. AGE (In years lost birthday) 57 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Benjamin Brown		14. MOTHER'S MAIDEN NAME Rosie Burgess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT Martha M. Parker - Patient	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Insufficiency			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far advanced bilateral cavitary pulmonary Tbc.			
DUE TO			
(c) Diabetes Mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 9, 1958 , to July 13, 1958 , that I last saw the deceased alive on July 13, 1958 , and that death occurred at 11 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <i>E. M. Maculans, M. D.</i>		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 7-13-58	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		Henryton State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-58	22c. NAME OF CEMETERY OR CREMATORIAL Adams Chapel
22d. LOCATION (City, town, or county) Bayard, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Rose, Jr. Anna, Md.</i>		24a. REC'D BY REGISTRAR DATE JUL 18 1958	24b. REGISTRAR'S SIGNATURE <i>John E. ...</i>

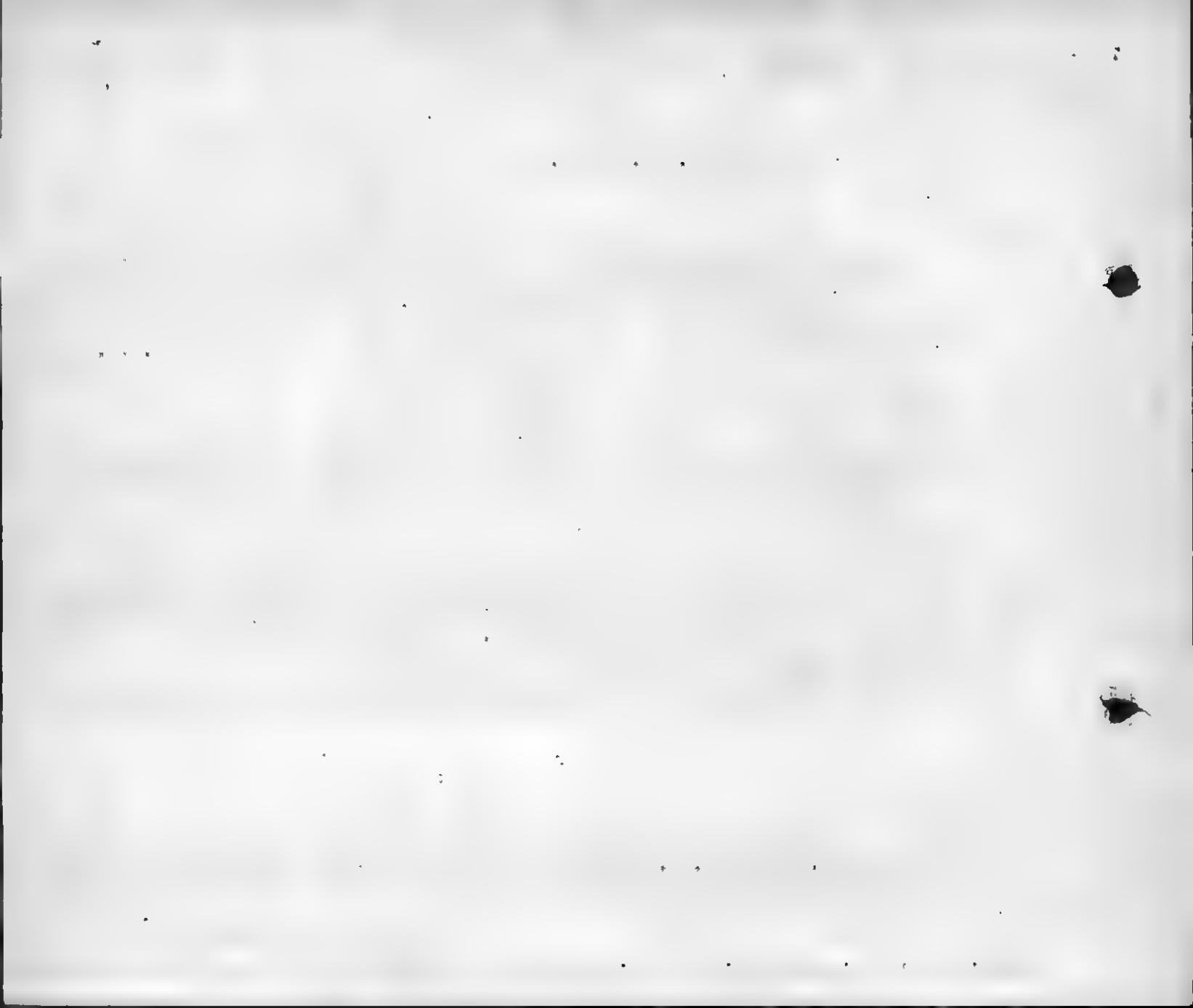


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar.

15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07842		
Item 7 Film 127775/58										Reg. Dist. No.		
7844 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural			c. LENGTH OF STAY IN 1b 5y. 8m. 21 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS 2810 Guilford Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Margaret	Middle Engle	Lost Prather	4. DATE OF DEATH July	Month 11	Day 1958	Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 23, 1858	9. AGE (In years last birthday) 29 yrs	IF UNDER 1 YEAR Months	Days	Hours	Min.	IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) OHIO			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Springfield Hospital Record			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Myocardial insufficiency</u>										INTERVAL BETWEEN ONSET AND DEATH hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with disturbance of growth, metabolism or nutrition, with psychotic reaction.										days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Springfield		(County)	(State)	
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>July 11, 1958</u> , that I last saw the deceased alive on <u>July 10, 1958</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>River S. Glehn</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <u>Rita S. Glehn, M. D.</u> Springfield State Hospital 7-11-58 DATE SIGNED												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF July 14, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park			22d. LOCATION (City, town, or county) Baltimore			(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St.					ADDRESS					24a. REC'D BY REGISTRAR DATE JUL 14 '58		
										24b. REGISTRAR'S SIGNATURE Alb. edrich		



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

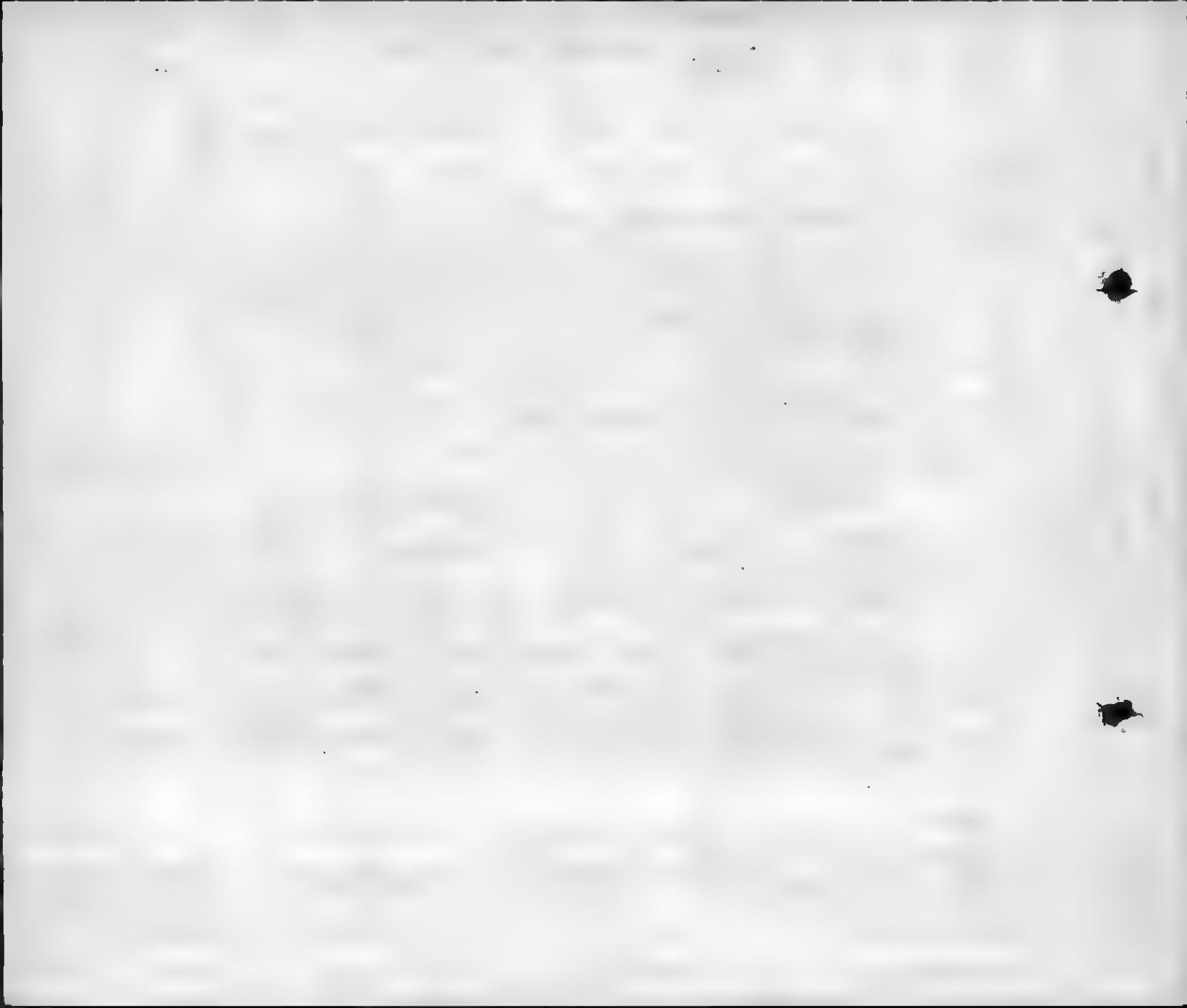
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7845 CERTIFICATE OF DEATH

07843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAMPSTEAD</i>		b. COUNTY <i>Carroll</i>	
c. LENGTH OF STAY IN 1b <i>12 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAMPSTEAD Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>202 S. Main St</i>		d. STREET ADDRESS <i>202 S Main</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SADIE</i>	First <i>Elizabeth</i>	Middle <i>Rhoten</i>	Last <i>July</i>
4. DATE OF DEATH <i>29</i>	Month <i>July</i>	Day <i>29</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 27 1867</i>
9. AGE (In years, lost birthday) yrs. <i>91</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>George W. Wilhelm</i>	14. MOTHER'S MAIDEN NAME <i>Ruth Brown</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	17. SOCIAL SECURITY NO. <i>none</i>	18. INFORMANT <i>Mrs Maude Wobbeling</i>	Address <i>Hampstead Md</i>
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture 2 left - hip</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on Living Room Floor.</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>6-1-1958</i> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED <i>1958</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Hampstead Carroll md</i>
21. I certify that I attended the deceased from <i>June 1</i> , 19 <i>58</i> , to <i>July 29</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>July 28</i> , 19 <i>58</i> , and that death occurred at <i>Hampstead Carroll md</i> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <i>Hampstead Md</i>	
ACTUAL SIGNATURE <i>Joseph E. Bush M.D.</i>	DATE SIGNED <i>7/29/58</i>		
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush M.D.</i>	23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		
24. DATE THEREOF <i>Aug 4-5-8</i>	25. NAME OF CEMETERY OR CREMATORIUM <i>St Paul's</i>	26. LOCATION (City, town, or county) <i>Hampstead Carroll md</i>	
27. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Norton Hampstead Md</i>	28. ADDRESS <i>Edgar Norton Hampstead Md</i>	29. REC'D BY REGISTRAR DATE JUL 31 '58	30. REGISTRAR'S SIGNATURE <i>Outreach</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7846 CERTIFICATE OF DEATH

Reg. Dist. No.

07844

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 20 yrs. 6 mos. 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 12	
3. NAME OF DECEASED (Type or print) Etha B. Roach		d. STREET ADDRESS 6707 Alleghany Ave.	
4. DATE OF DEATH July 15, 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884
9. AGE (In years from birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. York	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH Days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Arteriosclerotic heart disease. Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954, to July 15, 1958 , that I last saw the deceased alive on July 14, 1958 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield Hospital DATE SIGNED 7/15/58			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-58	
22c. NAME OF CEMETERY OR CREMATORIAL Springfield		22d. LOCATION (City, town, or county) Sykesville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Burke A. Height		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR JUL 21 '58		24b. REGISTRAR'S SIGNATURE A. L. Lusthaus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

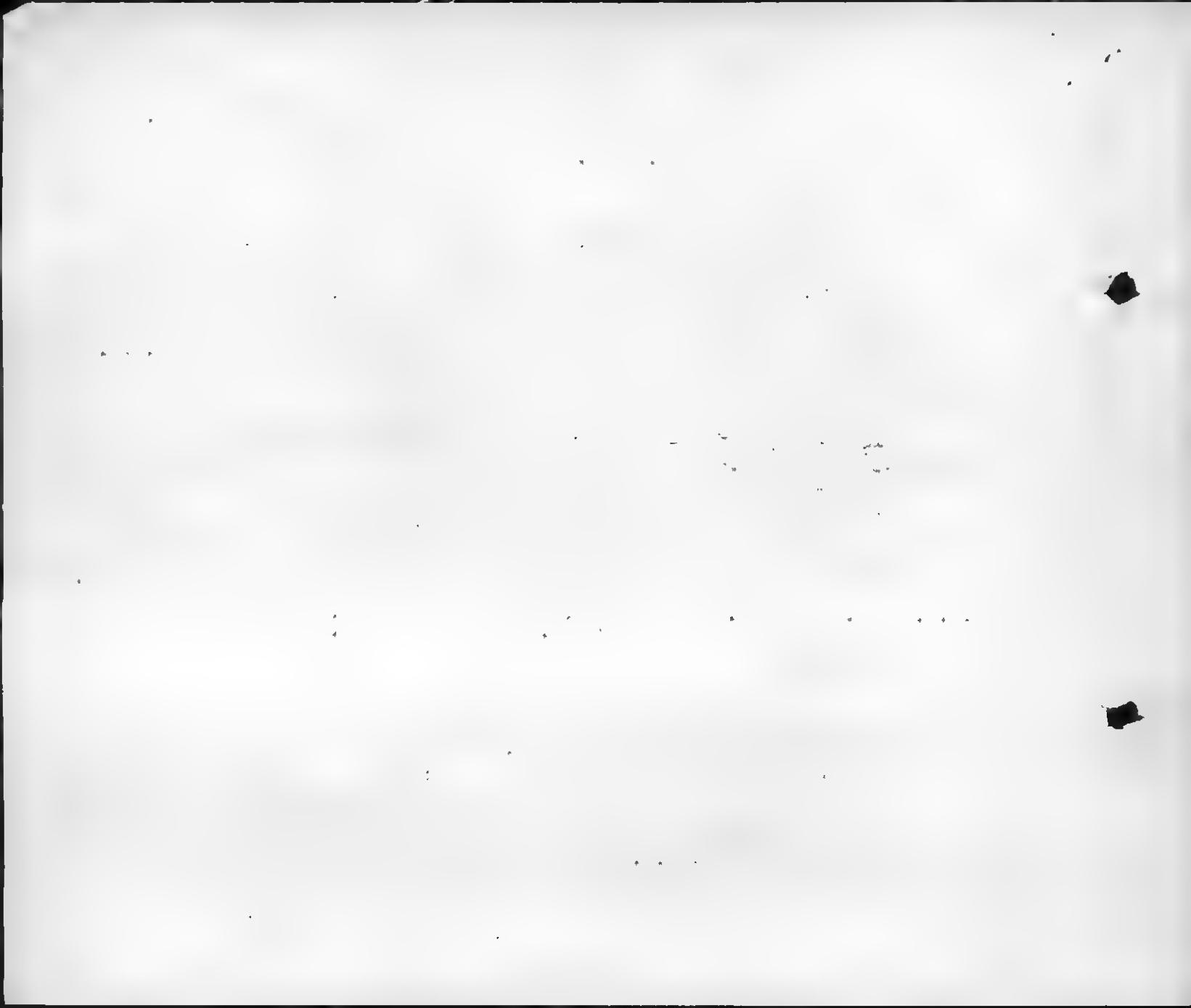
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07845

7847 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 10mos. 21days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First William Franklin		d. STREET ADDRESS 4033 Falls Road	
4. DATE OF DEATH July 30, 1958		Month July	Day 30
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH February 19, 1878	
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months 0	
11. IF UNDER 24 HRS Days 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lamp lighter		10b. KIND OF BUSINESS OR INDUSTRY BAL TO. CITY	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-05-9208	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia			
INTERVAL BETWEEN ONSET AND DEATH Days:			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Arteriosclerotic heart disease (c) Generalized arteriosclerosis			
Years			
Years.			
C. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVING PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. Secondary anemia.			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1955 to July 30, 1958 , that I last saw the deceased alive on July 30, 1958 , and that death occurred at 8:45A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED 7/30/58			
ACTUAL SIGNATURE Agustin del Campo M.D.			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Special Burial)		22b. DATE THEREOF Aug 3 1958	
22c. NAME OF CEMETERY OR CREMATORIUM St. Marys		22d. LOCATION (City, town, or county) Balto.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Branard Jr.		24a. REC'D BY REGISTRAR AUG 1 '58	
ADDRESS 3615-17-19 Chestnut		24b. REGISTRAR'S SIGNATURE Alf. Smith	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing in a word "Pending in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 should be retained for your files.
TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME
SM 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7848 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If inst. tell town. Residence before admission) a. STATE MD	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		b. COUNTY CARROLL	
c. LENGTH OF STAY IN lb 11		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) INTERIDERS CHURCH		d. STREET ADDRESS Fountain Valley	
3. NAME OF DECEASED (Type or print) JANIA		First LOUISE	Middle STARNER
4. DATE OF DEATH JULY 27		Month JULY	Day 27
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH AUG 4 1892		9. AGE (in years to nearest birthday) 65 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) M.D.	
13. FATHER'S NAME HARRY LITTLE		14. MOTHER'S MAIDEN NAME ANNIE MCCARTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NC		16. SOCIAL SECURITY NO. 17. INFORMANT M. L. LITTLE PAUL STARNER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. FOUNTAIN VALLEY INTERVAL BETWEEN ONSET AND DEATH MIN	
20. CORONARY OCCLUSION		20. CORONARY SCLEROSIS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. DIABETES MELLITUS		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20b. PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 7/27/58	
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		22b. DATE THEREOF JULY 31/58	
22c. NAME OF CEMETERY OR CREMATORIUM WESTMINSTER		22d. LOCATION (City, town, or county) (State) M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold B. Washington, Inc.		24a. REC'D BY REGISTRAR DATE JUL 30 1958	
ADDRESS 1111 Baltimore Washington, Inc.		24b. REGISTRAR'S SIGNATURE Rehman	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached from this certificate and given to the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7849

CERTIFICATE OF DEATH

Reg. Dist. No.

07847

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 141 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill	
3. NAME OF DECEASED (Type or print) John		d. STREET ADDRESS	
4. DATE OF DEATH Stevenson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1872
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Georgianna Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 215-32-4444	
17. INFORMANT John Stevenson - Patient		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Aneurysm of the aorta DUE TO (c) pulmonary tuberculosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1958 , to July 29, 1958 , that I last saw the deceased alive on July 29, 1958 , and that death occurred at 8:15 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 8. M. Maculans, M. D. M.D. DATE SIGNED Henryton, Maryland			
22a. PHYSICIAN'S NAME (Type) E. M. Maculans, M. D., Supt.		22b. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22c. DATE THEREOF 8-2-58		22d. NAME OF CEMETERY OR CREMATORIUM Ashbury Cemetery	
22e. LOCATION (City, town, or county) Loreley, Balto. Co., Md.		22f. ADDRESS 23. FUNERAL DIRECTOR'S SIGNATURE Newark McCloud Abingdon Md	
24a. REC'D BY REGISTRAR DATE JUL 31 '58		24b. REGISTRAR'S SIGNATURE Asst. Sec. C	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

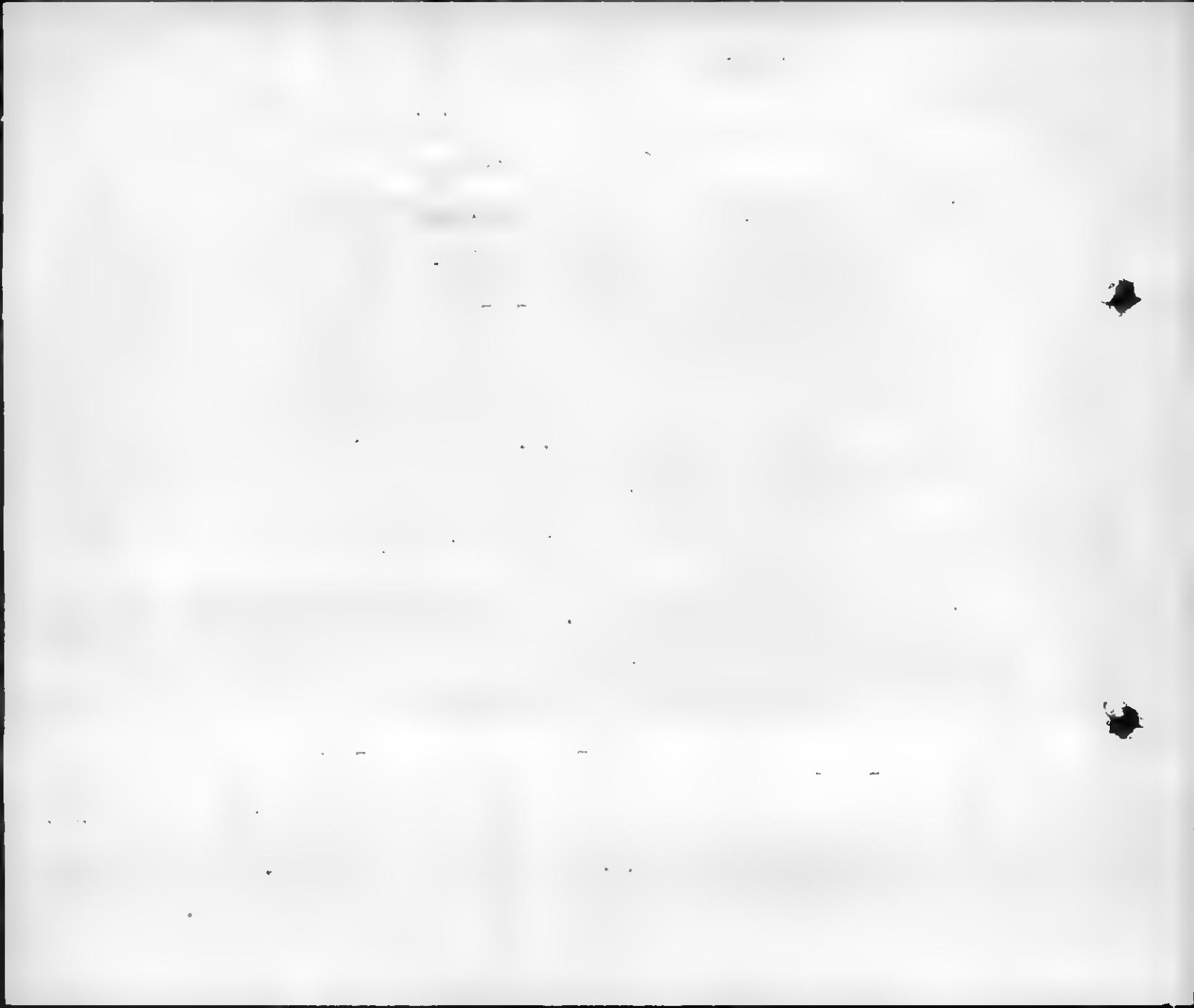
07848

CERTIFICATE OF DEATH

Reg. Dist. No.

7850

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2 y 6 m 8 d		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		f. STREET ADDRESS 53 E. Franklin Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ellen	First	Middle Anelda	Last Sullivan	4. DATE OF DEATH 7	Month 12	Day 1958	Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-31- 86	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? Naturalized				
13. FATHER'S NAME Timothy Hurley			14. MOTHER'S MAIDEN NAME Nora Curran Hurley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S. Hospital Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis, minimal, inactive DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. Fracture Intertrochanteric, left femur									years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell from wheelchair							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 4	Day 11	Year 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) on ward	20f. (City or town) Hagerstown	(County) Md.	(State) Md.		
21. I certify that I attended the deceased from 1-4- , 19 56 , to 7-12- , 19 58 , that I last saw the deceased alive on 7- 11- , 19 58 , and that death occurred at 8:30 AM , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) Springfield State Hospital	DATE SIGNED 7-12-58
ACTUAL SIGNATURE <i>Julian Radzykewytch</i>	PHYSICIAN'S NAME (Type) Julian Radzykewytch M.D.								Sykesville, Maryland.	
22a. BURIAL CREMATION BURIAL	22b. DATE THEREOF 7-16-58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Md.	(State) Md.						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gerald N. Minnick</i>	ADDRESS Hagerstown	24a. REC'D BY REGISTRAR DATE JUL 15 '58	24b. REGISTRAR'S SIGNATURE <i>Albert E. Smith</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After page 3 has been signed by the attending physician and completed, fill in by the funeral director. page 3 should be detached from the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

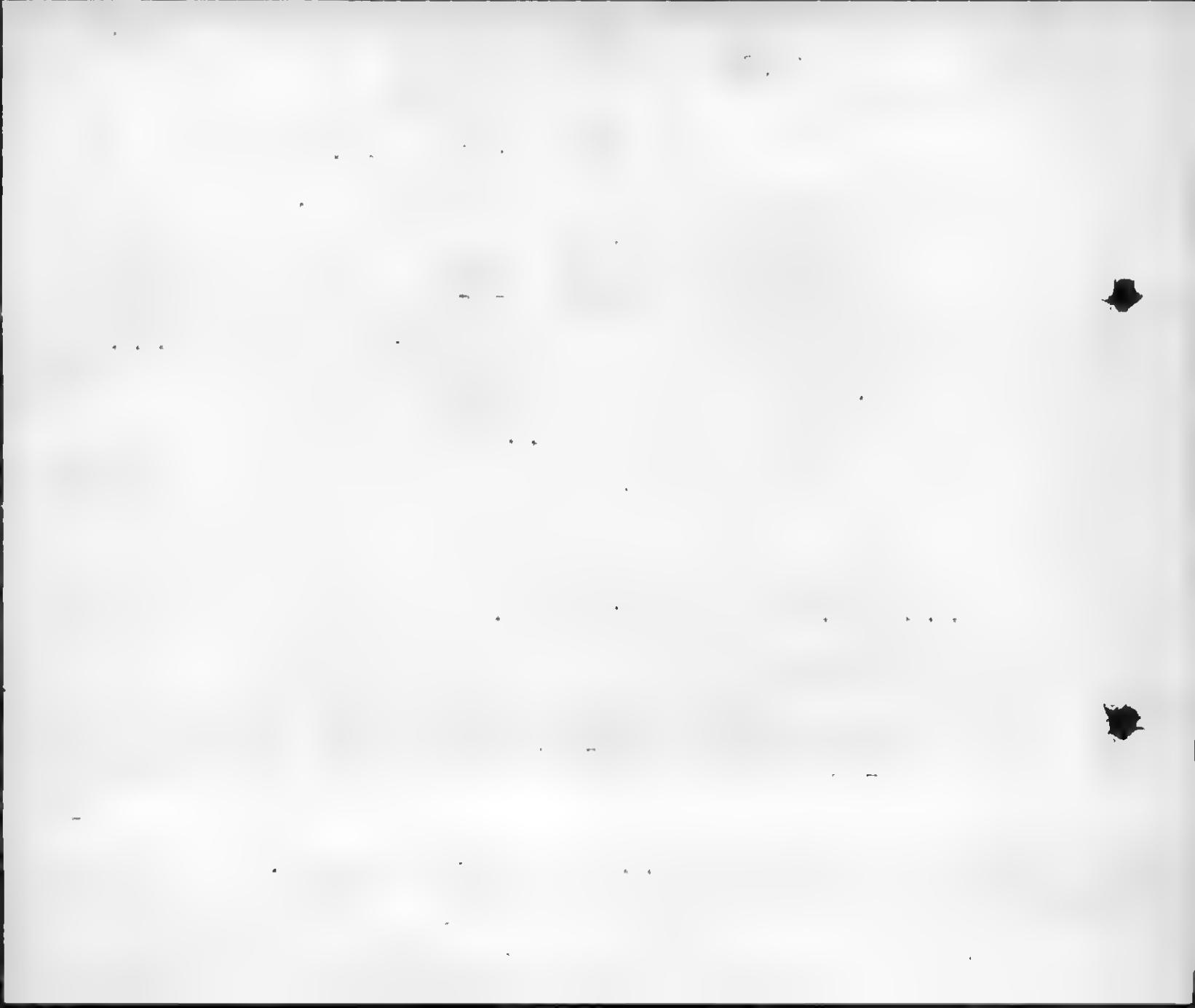
7851

CERTIFICATE OF DEATH

07849

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Maryland			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY City			
c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2803 Guilford Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Helen	Middle Elizabeth	Last Sutton		
4. DATE OF DEATH	Month 7	Day 13	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-65		
9. AGE (In years last birthday) 93 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel E. Kirk	14. MOTHER'S MAIDEN NAME Martha Cole	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO union	17. INFORMANT S.S. Hospital Records	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 440.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). (b) DUE TO (c) DUE TO C.B.S. assoc. with cerebral arterioscler.	INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Maryland
21. I certify that I attended the deceased from alive on 7-12-1958, and that death occurred 6:31 AM, from the causes and on the date stated above.	ADDRESS (Street, city or town, state) Edmund Lusthaus, M.D., Springfield State Hospital DATE SIGNED 7-13-58				
ACTUAL SIGNATURE Edmund Lusthaus	PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D., Sykesville, Maryland.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 15, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cem.	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC., Baltimore, Md.	ADDRESS	24a. REC'D BY REGISTRAR JUL 16 '58	24b. REGISTRAR'S SIGNATURE A. L. Sander		
VS A15 (4) 15M 10/57	DATE				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7852

CERTIFICATE OF DEATH

07850

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b
RURAL and give nearest town)

1 y 2 m 15 d

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE

Maryland

b. COUNTY

City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore 13, Md.

d. STREET ADDRESS

3010 Kenyon Avenue

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)10. IF UNDER 1 YEAR
Months Days Hours Min

Female

White

WIDOWED DIVORCED

7-4-76

82

yrs.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Theodore Perry

14. MOTHER'S MAIDEN NAME

Ida Banke

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) [If yes, give war or date of service]

16. SOCIAL SECURITY NO.

no

unkn

17. INFORMANT

Address

S.S. Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH
daysConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b) Nephritis due to Septicemia

weeks

(c) Decubitus Ulcer

weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
1. C.B.S. assoc. with cerebral arteriosclerosis, with psych. reaction PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Pt. fell injuring right hip

20c. TIME OF INJURY Month, Day, Year

Hour a. m. 6 4 58
p. m. 1920d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg. etc.)

20f. (City or town)

(County)

(State)

Ward S.S. Hospital, Sykesville, Md.

21. I certify that I attended the deceased from 4-20-1957 to 7-4-1958, that I last saw the deceased
alive on 7-4-1958, and that death occurred at 2:20 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Edmund Lusthaus, M.D.

Sykesville, Maryland

7-5-58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7-8-1958

22c. NAME OF CEMETERY OR CREMATORI

Parkwood

22d. LOCATION (City, town, or county)

(State)

Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Lassen Funeral Home

7401 Blau Rd.

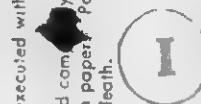
24a. REC'D BY REGISTRAR
DATE JUL 8 '5824b. REGISTRAR'S SIGNATURE
Olden



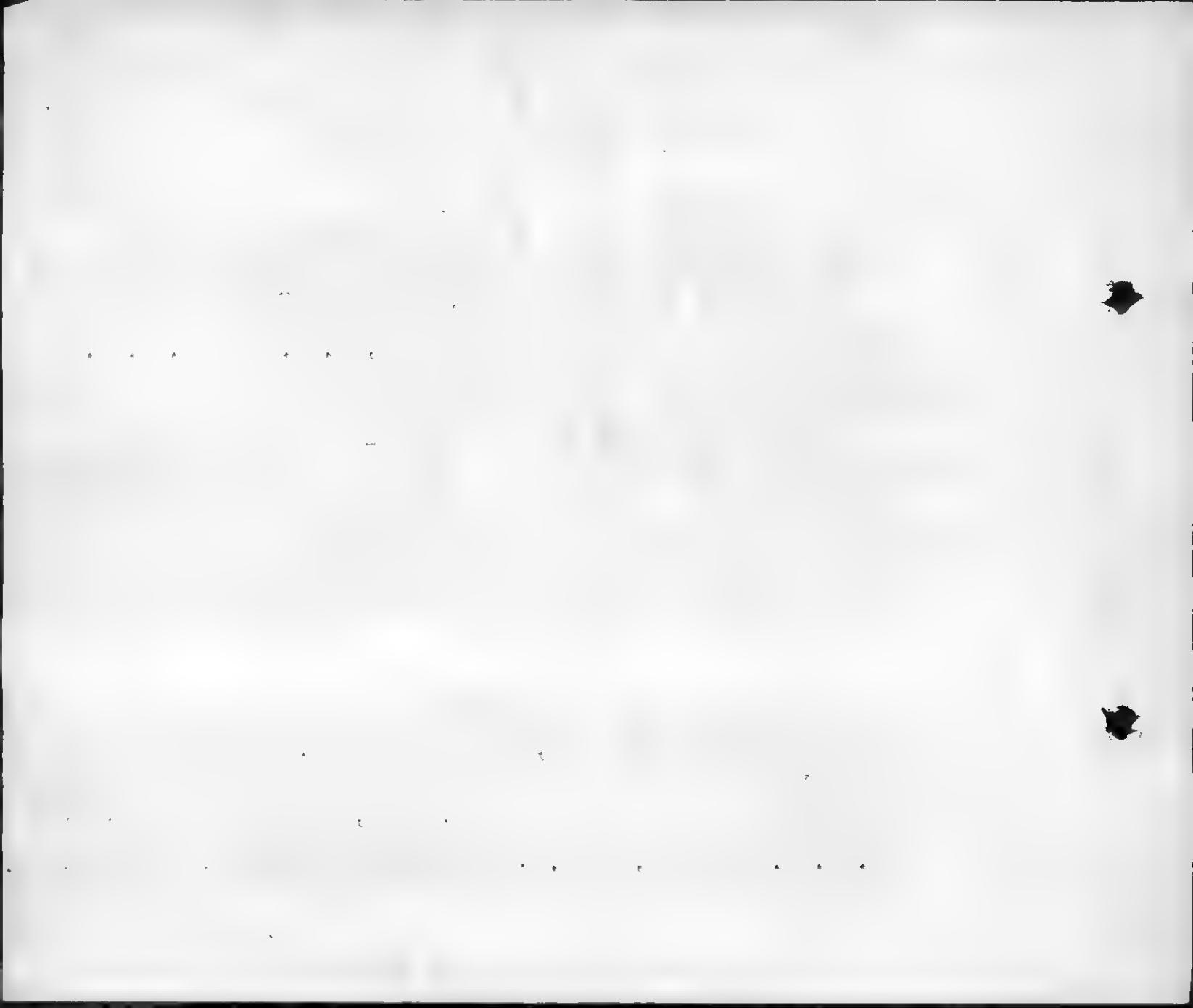
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18															
7853 Film G231 7/22/58 Items 22abcd CERTIFICATE OF DEATH															
Reg. Dist. No. 07851															
1. PLACE OF DEATH a. COUNTY Carroll				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 2 days				b. COUNTY Prince George's							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital								e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaver Heights							
3. NAME OF DECEASED (Type or print) Daniel				First		Middle		Lost Tyler		4. DATE OF DEATH July	Month 17	Day 19	Year 58		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1915		9. AGE (In years last birthday) 43 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Orangeburg, S. C.				12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME Mack Tyler				14. MOTHER'S MAIDEN NAME Luellen Jamison											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <input type="checkbox"/> If yes, give war or dates of service No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Beatrice Tyler-Wife		Address 4612 R Street									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular disease															
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) Meningitis or cerebral tumor															
DUE TO Far advanced pulmonary tuberculosis (c)															
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from July 16, 1958 to July 17, 1958 that I last saw the deceased alive on July 17, 1958, and that death occurred at 7:25 p.m., from the causes and on the date stated above.												ADDRESS (Street, city or town, state)		DATE SIGNED 7-17-58	
ACTUAL SIGNATURE E. M. Maculans, M.D.								Henryton, Maryland							
PHYSICIAN'S NAME (Type) DR. E. M. Maculans, Supt. Henryton State Hospital, Henryton, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/21/58		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cem.				22d. LOCATION (City, town, or county) Washington, D. C.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Petworth Funeral Home T.S.C.		ADDRESS 814 - upstair 57 NW		24a. REC'D BY REGISTRAR DATE JUL 21 '58				24b. REGISTRAR'S SIGNATURE Aut. edie							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached from page 4 as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

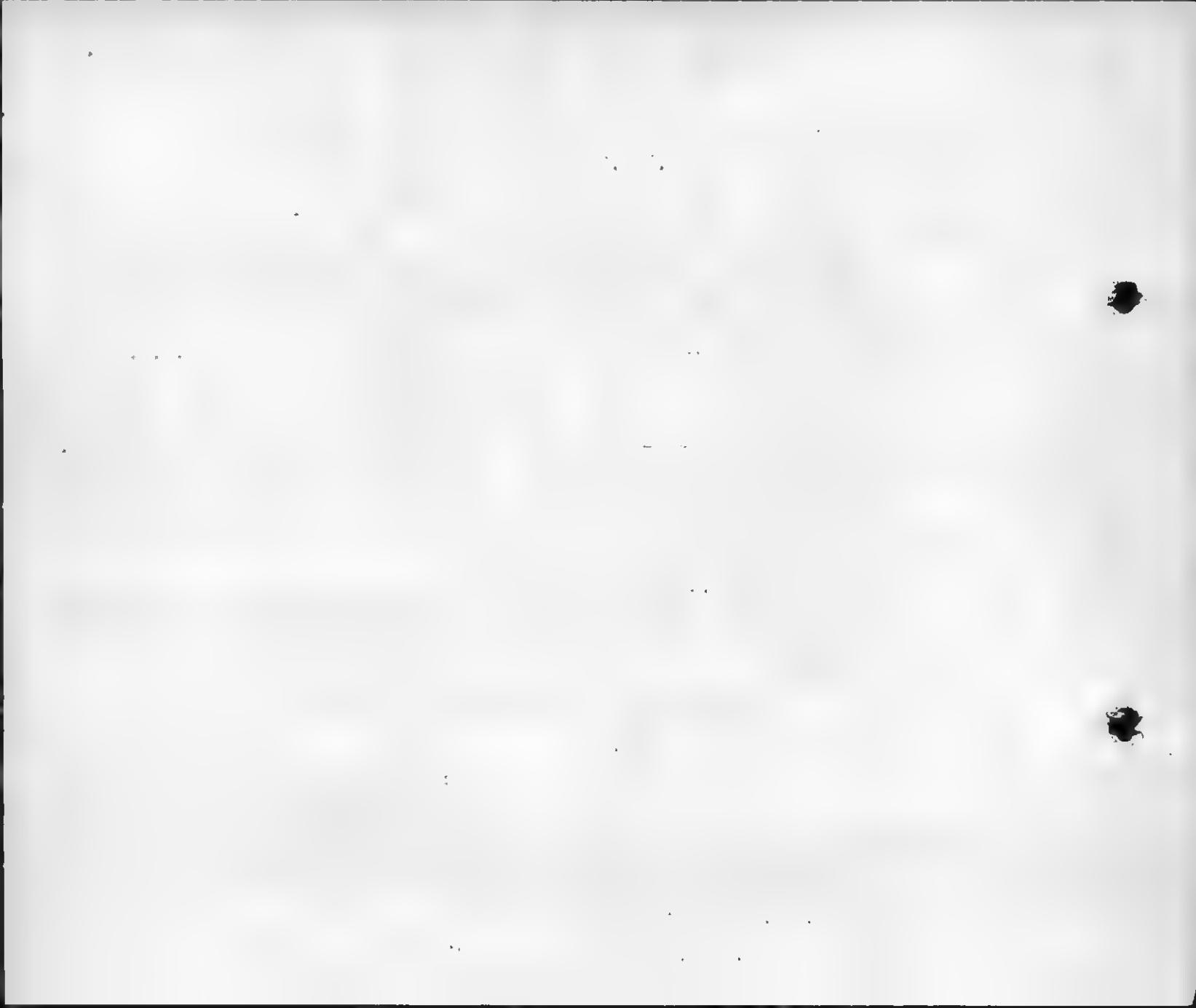
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7854 CERTIFICATE OF DEATH

07852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		b. COUNTY Baltimore City	
c. LENGTH OF STAY IN 1b lyr. 1mo. 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1763 Montpelier St.	
3. NAME OF DECEASED (Type or print)	First Wilburt	Middle David	4. DATE OF DEATH 7/23/58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/73
9. AGE (In years lost birthday) 84	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. IF UNDER 24 HRS Min 0	14. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-01-3600	17. INFORMANT Katharine Spencer	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal bronchopneumonia			
491X Not due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) Arteriosclerotic cardiac-vascular and cerebral disease years -DUE TO Generalized arteriosclerosis years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/24 , 19 57 , to 7/23 , 19 58 , that I last saw the deceased alive on 7/23 , 19 58 , and that death occurred at 6:35 p.m., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Maryland			
DATE SIGNED Agustín del Campo			
ACTUAL SIGNATURE Agustín del Campo			
PHYSICIAN'S NAME (Type) Agustín del Campo			
Maryland, July 24, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 26, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS. INC. Baltimore Md.	ADDRESS HENRY SANDER & SONS. INC. Baltimore Md.	24a. REC'D BY REGISTRAR DATE JUL 28 '58	24b. REGISTRAR'S SIGNATURE W. J. Sander



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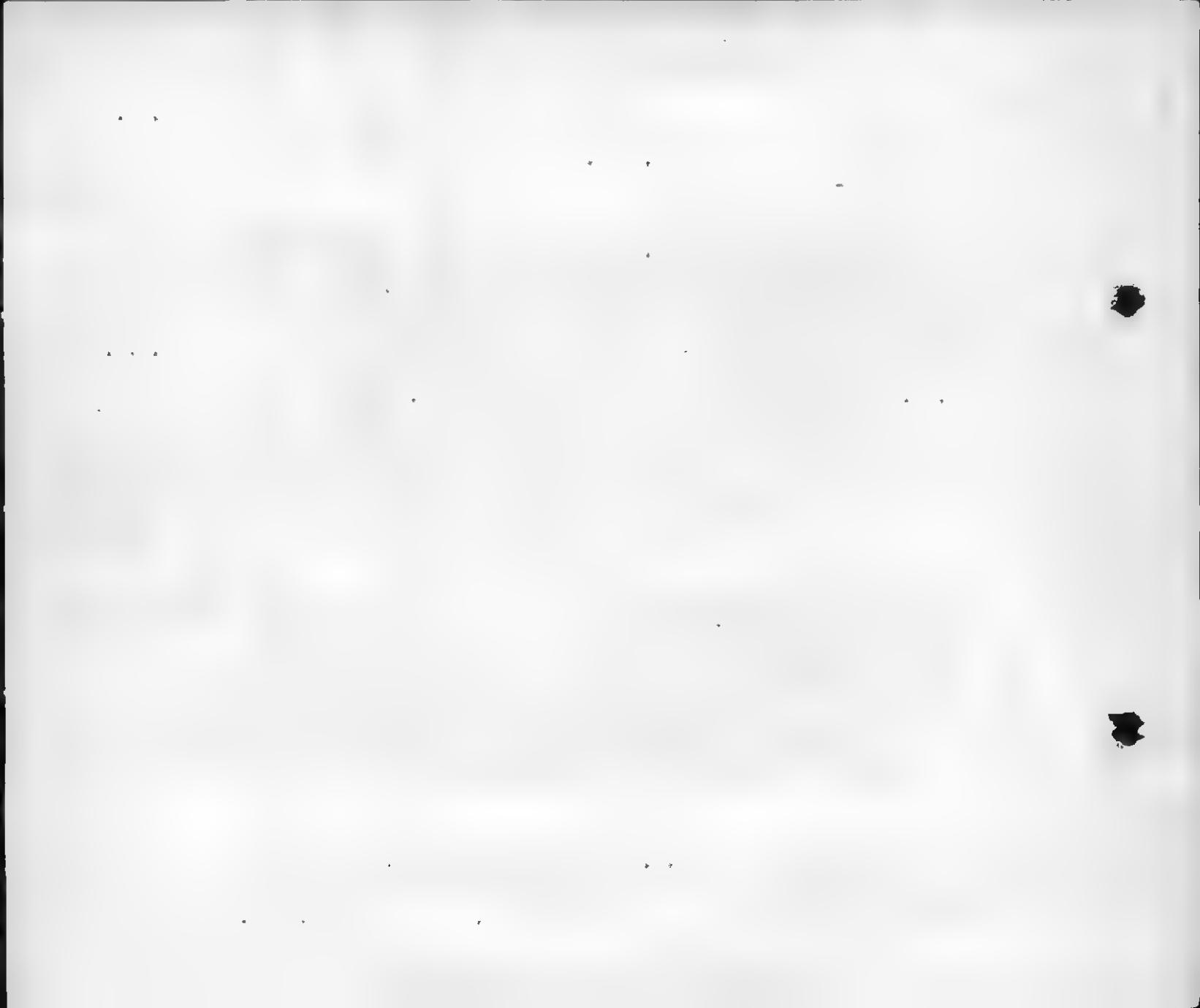
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7855 CERTIFICATE OF DEATH

07853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 30 yrs, 2 mos, 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
3. NAME OF DECEASED (Type or print) Ross		First C.	Middle Wiest
4. DATE OF DEATH July 7, 1958	Month July	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 21, 1905
9. AGE (In years less than 100 years) 53	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 3	12. IF UNDER 24 HRS Hours 0
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. R. Wiest		14. MOTHER'S MAIDEN NAME Maud O. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO -	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma of the colon (c) DUE TO Carcinoma of the lung INTERVAL BETWEEN ONSET AND DEATH Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dementia Praecox, hebephrenic Months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1958 , to July 7, 1958 , that I last saw the deceased alive on July 7, 1958 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/8/58			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/58	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.	22d. LOCATION (City, town, or county) Balto., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Lickner & Sons, Inc.</i>		24a. REC'D BY REGISTRAR DATE JUL 9 '58	24b. REGISTRAR'S SIGNATURE <i>Dee. 1958</i>



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07854

7856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 16 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) William ASH		First	Middle
4. DATE OF DEATH WILSON		Month 7	Day 3
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/80
9. AGE (In years last birthday) 78	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer	10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Wilson		14. MOTHER'S MAIDEN NAME Grace Peacock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-10-5602	17. INFORMANT Record, Springfield State Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X 26036		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. X 26036		years	
(b) Arteriosclerotic heart disease		years	
(c) Diabetes Mellitus		years	
260 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with senile brain disease, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		6/17, 1958	7/3, 1958
		12.55A	DSM
		M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Gertrude M. Gross		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M. D.		DATE SIGNED 7/3/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-4-58	22c. NAME OF CEMETERY OR CREMATORIUM Springfield	22d. LOCATION (City, town, or county) Sykesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. H. Haight	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 9 '58	24b. REGISTRAR'S SIGNATURE A. L. Smith

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HTABD 50 STADTFWGD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07855

7857

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 yrs. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ramer	Middle Calvin	Last YOUNKINS
4. DATE OF DEATH	Month July	Day 9,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1872
9. AGE (In years less birthday) 85 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. KIND OF BUSINESS OR INDUSTRY -	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Carl Younkins	14. MOTHER'S MAIDEN NAME Ella Sigler	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -	17. INFORMANT Springfield Hospital Records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). 471X			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 22, 1956 to July 9, 1958 , that I last saw the deceased alive on July 9, 1958 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 7/9/58	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-58	22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cem.
22d. LOCATION (City, town, or county) Middletown		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray C. Madeline</i>		24a. REC'D BY REGISTRAR DATE JUL 14 '58	24b. REGISTRAR'S SIGNATURE <i>Albrecht</i>

west 166.39 199-9 ~~200-9~~ 62-11-2 199-1
west 166.39 200-9 62-11-2 199-1